VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070
802 657-4220 or 800-745-7371

2006 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

License Number: 042-0005990

1. **Your legal name:**

   Susan Smith

   a. Have you ever legally changed your name? ___Yes _X_ No

   If yes, enter your former name and any other name(s) under which you were licensed in Vermont or elsewhere in the past two years;

Last Name	First Name	Middle Name:	Suffix

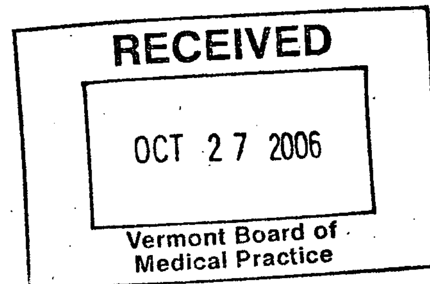
   b. Indicate your name, as it should appear on your license:

Last Name	First Name	Middle Name:	Suffix
Smith	Susan		

2. **Your Date of Birth:** 01/26/1944

3. **Home Address and email address:**

   Women's Choice Gynecologic Assoc.
   23 Mansfield Avenue
   Burlington, VT 05401
   SUSANS@PPNNE.ORG



4. **Work Address:**

   Women's Choice Gynecologic Assoc.
   23 Mansfield Avenue
   Burlington, VT 05401
   SUSANS@PPNNE.ORG

5. **Please check your preferred mailing address:** ____ **Home** _X_ **Work**
   NOTE: *The mailing address will be publicly listed on the Board's web site.*

6. **Home Telephone Number with Area Code:** (802) 250 1263

7. **Work Telephone Number with Area Code:** (802) 863 9001

8. **E-mail address (if not appearing in #3):**

___

Please check here if the Department of Health may use this e-mail address to send you public health information.
☒ yes ☐ no

PART II

9. Were you in active practice in Vermont in the past 12 Months? ☒ yes ☐ no

10. Do you hold, or have you ever held, a medical license (including temporary) in any other state?
☒ yes ☐ no

If yes, complete the section below and attach additional pages if necessary.

State	License Number	Type of License	Date Issued	Status (Active, Inactive, or other, e.g. conditioned, restricted, limited)
NH 1994	9340	medical	12/7/94	active
ME 2001	015518	medical	2/8/01	active

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED ON THE ENCLOSED FORM A.

11. Have you ever applied for and been denied a license to practice medicine or any other healing art?
☐ yes ☒ no

12. Have you ever withdrawn an application for a license to practice medicine or any other healing art?
☐ yes ☒ no

13. Have you ever voluntarily suspended, surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action?
☐ yes ☒ no

14. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
☐ yes ☒ no

15. Have you ever been denied the privilege of taking an examination before any state medical examining board?
☐ yes ☒ no

16. Have you ever discontinued your education, training, or practice for a period of more than three months for reasons other than a family need?
☐ yes ☒ no

17. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
☐ yes ☒ no

18. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?
☐ yes ☒ no

19. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
☐ yes ☒ no

20. Are you presently or have you ever been a defendant in a criminal proceeding?

☐ yes ☒ no

PART III

(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

21. To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application?

22. To your knowledge, are you presently the subject of a criminal investigation?

The following definitions are provided to assist you in answering questions 23 through 25.

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"Chemical substances" - This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

23. Do you have a medical condition that in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

24. Are you currently engaged in the use of alcohol or other chemical substances that in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

25. Are you currently engaged in the illegal use of controlled substances?

CONFIDENTIAL ASSISTANCE IS AVAILABLE

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a service of the Vermont Medical Society. This is a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. For further information about this program, call 802-223-0400 (a confidential line).

PART IV

The following questions are required by Vermont law, 26 VSA § 1368, to update and maintain a data repository within the Department of Health and to make individual profiles on all health care professionals licensed, certified, or registered by the Department available to the public. Your physician profile is located at the following website http://healthvermont.gov.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 26 through 31 have changed since your last application. We cannot process your application without them.

26. **Criminal Convictions** [26 VSA § 1368(a)(1)] ☒ Check here if none

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past ten years not listed below. **Please provide complete copies of documentation for each matter.**

None reported

(Conviction Date) (Court) (City/State) (Crime)

27. **Nolo Contendere/Matters Continued** [26 VSA § 1368(a)(2)] ☒ Check here if none

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction not listed below. **Please provide complete copies of documentation for each matter.**

None reported

(Conviction Date) (Court) (City/State) (Charge)

28. **Vermont Board of Medical Practice Matters** [26 VSA § 1368(a)(3)] ☒ Check here if none

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

None reported

(Date) (Final Disposition - Summary)

29. <u>**Licensing or Certification Authority Matters in Other States**</u> [26 VSA § 1368(a)(4)]

☒ Check here if none

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states, if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

(Date of Final Disposition)(Licensing or Certification Authority) (Court) (City/State) (Nature of Charge)

30. <u>**Restriction of Hospital Privileges**</u> [26 VSA § 1368(a)(5)]

A. <u>Revocation/Involuntary Restrictions</u> ☒ Check here if none

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

(Date) (Hospital) (State) (Nature of Restriction) (Reason for Restriction)

B. <u>Other Restrictions</u> ☒ Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

(Date) (Hospital) (State)

(Nature of Action) (Action)

☐ In lieu ☐ In settlement

(Reason for Action)

31. <u>**Medical Malpractice Court Judgments/Settlements**</u> [26 VSA § 1368(a)(6A)]

A. <u>Judgments</u> ☒ Check here if none

Please complete the attached Form A and provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past

10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

None reported

☐ Judgement ☐ Arbitration

(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Against You)

B. **Settlements** ☒ Check here if none

Please provide a description of all settlements of medical malpractice claims against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

None reported

(Date)	(Court)	(State)	(Amount of Settlement Against You)

32. **Medical Professional Schools** [26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation if not listed below.

UNIVERSITY OF MICHIGAN, MI

1976

33. **Graduate Medical Education/Residency** [26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Fletcher Allen Health Care ,VT

Obstetrics and Gynecology

1980

(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation)
(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation)

If necessary, please use an additional sheet and check this box: .....

34. **Specialty Board Certification** [26 VSA § 1368(a)(9)]

Please verify the following information regarding your specialty board certification and update as necessary using the attached Specialty Codes List.

Obstetrics and Gynecology
American Board of Obstetrics and Gynecology
1982

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
		☐ yes ☐ no			
		☐ yes ☐ no			

35. **Years of Practice** [26 VSA § 1368(a)(10)]

Month and year you started practicing as a physician? **8//1980**

36. **Hospital Privileges** [26 VSA § 1368(a)(11)] ☐ Check here if none

List all information for all hospitals where you currently have hospital staff privileges if not listed below:

Fletcher Allen (FAHC, MCHV)
VT
(1980-)

(Name) (City) (State) (Year Started)

37. **Appointments/Teaching** [26 VSA § 1368(a)(12)]

Note: Answering #37 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

A. Appointments ☐ Check here if none

Please provide information about your appointments to medical school or professional school faculties if not listed.

University of Vermont
Burlington, VT
Occasional didactic presentation
1992 - PRESENT

University of Vermont
Burlington, VT
Regular supervision of resident clinics
1996 - 2004

University of Vermont
Burlington, VT
Clinical teaching in emergency department, OR and inpatient wards
1992 - present

(School) (City) (State) (Nature of Appointment) From (year) To (year)

B. Teaching ☐ Check here if none

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

University of Vermont
Burlington, VT
Occasional didactic presentation

1992 - PRESENT

University of Vermont
Burlington, VT
Regular supervision of resident clinics
1996 - 2004

University of Vermont
Burlington, VT
Clinical teaching in emergency department, OR and inpatient wards
1992 - present

(School/Institution) (City) (State) (Nature of Teaching) From (year) To (year)

38. **Publications**: [26 VSA § 1368(a)(13)] ☒ Check here if none

Note: Answering #38 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not listed.

(Title) (Publication) (Year)

(Title) (Publication) (Year)

(Title) (Publication) (Year)

39. **Activities** [26 VSA § 1368(a)(14)] ☒ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your professional or community service activities and awards if not listed.

None reported

(Activities or Awards)

(Activities or Awards)

(Activities or Awards)

40. **Practice Setting** [26 VSA § 1368(a)(15)] ☐ Check here if none

What is the location of your primary practice setting? **BURLINGTON, VT**

41. **Translating Services** [26 VSA § 1368(a)(16)] ☒ Check here if none

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location? ☐ Not applicable

If yes, please describe here the translating services available:

None

If necessary, please use an additional sheet and check this box: ......☐

42. **Medicaid/New Patients** [26 VSA § 1368(a)(17)]

A. Medicaid participation

Do you participate in the Medicaid program? ☒ yes ☐ no ☐ not applicable

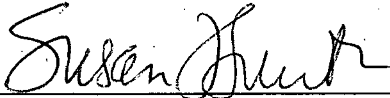
B. New Medicaid Patients

Are you currently accepting new Medicaid patients? ☒ yes ☐ no ☐ not applicable

Part V

I hereby affirm that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date: 10/24/06



Applicant's Signature

Reminder - You must also complete the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions regardless of whether or not you have children

Physician Profile Update

26 VSA § 1368 requires the Department to provide you with a copy of your profile prior to the initial release to the public and each time your profile is modified or amended. We intend to use the information in your renewal application for your physician profile.

Please let us know whether you wish to have your profile omit the following information by checking the "OMIT" box below. If the box is not checked, we will include the information in your profile:

OMIT FROM PROFILE

- ☐ Appointments to medical school or professional school faculties, and an indication as to whether you have had a responsibility for teaching graduate medical education within the last 10 years.
- ☐ Information regarding publications in peer-reviewed medical literature within the last 10 years.
- ☐ Information regarding professional or community service activities and awards.

Again, thank you for your cooperation.

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 11 and 12) Withdrawal or denial of License - Attach documents

State______________________________ Year__________
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated______________________________

____

(Question 13) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State______________________________ Year__________

Circumstances______________________________

____

(Question 14) Disciplinary charges or action - Attach documents

Name of organization involved______________________________ Date__________

Duration______________________________

Action taken (circle all that apply)

01 Revocation of right or privilege
02 Suspension of right or privilege
03 Censure
04 Written reprimand or admonition
05 Restriction of right or privilege
06 Non-renewal of right or privilege
07 Fine
08 Required performance of public service
09 Education/Training/Counseling/Monitoring
10 Denial of rights or privilege
11 Resignation
12 Leave of absence
13 Withdrawal of an application
14 Termination or non-renewal of contract
15 Medical Records Suspension
16 Probation
17 Assurance of Discontinuance
18 Consent Agreement
19 Letter of Agreement
20 Expulsion from Membership
21 Reprimand
22 Other (specify)__________

Circumstances______________________________

____

____

(Question 15) Denial of examination privileges - Attach documents

State______________________________ Year__________

Circumstances under which examination privileges denied ______________________________

____

____

(Questions 16 and 17) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) ______________________________

Location of Programs ______________________________ Year ____________

Circumstances______________________________

____

(Question 18) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved ______________________________

Location ______________________________ Year ____________

Circumstances______________________________

____

(Question 19) Privilege to prescribe controlled substances - Attach documents

Name of organization involved ______________________________

Type of restriction ______________________________ Date ____________

Circumstances of restriction

____

____

____

____

(Questions 20 and 22) Criminal Investigation - Proceeding - Attach documents

Court ______________________________

City and State ______________________________

Charge ______________________________

Description ______________________________

____

____

Status______________________________

____

Conviction? _____ Yes _____ No Date ______________________________

Plea? _____ Yes _____ No Date ______________________________

(Question 21) Investigation by any other licensing board - Attach documents

Name of Licensing Board ______________________________ Date ____________

Location of Licensing Board ______________________________

Circumstances ______________________________

(Questions 23-24) Medical condition, treatment, use of chemical or illegal substances

Treating organization ______________________________

Address ______________________________ Telephone ____________

Type of diagnosis, condition or treatment - field of practice - use of chemical substances

____

____

Dates of illness or dependency ______________ to ______________

Dates of treatment ______________ to ______________

Name of Rehabilitation/Professional Assistance or Monitoring Program ______________

Address ______________________________ Telephone ____________

Contact person at Program ______________________________

(Question 31) Medical Malpractice Claim

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.

Insurer ______________________________

Claimant name ______________________________

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

Please indicate:

1. Patient's condition at point of your involvement;
2. Patient's condition at end of treatment;
3. The nature and extent of your involvement with the patient;
4. Your degree of responsibility for the course of treatment in leading to the claim; and
5. Narrative of event.

____

____

____

____

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

Your role (circle one):

01 Anesthesiologist
02 Primary Care Physician
03 Referring Physician
04 Attending Physician
05 Consultant Specialist
06 Surgeon
07 Fellow
08 PGY 1
09 PGY 2
10 PGY 3
11 PGY 4
12 PGY 5
13 PGY 6
14 PGY 7
15 Workmen's Compensation Evaluator
16 Court Psychiatrist
17 On-Call Physician
18 Group Practitioner/Partner
19 Other: Specify ____________________
20 Unknown

Your Legal Representative in this matter (include name, address and telephone number)

Name ____

Firm ____

Address ____

City, State, Zip ____

Phone ____

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:

Court____

Court's location____

Docket number____

Date the action was filed____

Decision determined by (check one): ______ Judge ______ Jury ________ Arbitration Panel

Decision: ____________________________________ Award: ______________________________

If your case was appealed, indicate the following: Date appeal filed (month, day, year) _____/_____/_____
Date appeal decided: (month, day, year) _____/_____/_____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: ____________________________

Total settlement amount: ____

Date of settlement: (month, day, year) _____/_____/_____

_____ Case dismissed against you _____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

____

____

____

Vermont Department of Health - Board of Medical Practice
APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

1. You must check one of the two statements below regarding child support regardless whether or not you have children:

- [x] I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

or

- [ ] I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes."Good standing" means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

2. You must check one of the two statements below regarding taxes:

- [x] I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000.00 fine or both).

or

- [ ] I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contributions:

- [ ] I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a $10, 000.00 fine or both.)

or

- [ ] I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.

or

- [x] I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* [redacted] Date of Birth 1/26/44

* The disclosure of your social security number is mandatory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

STATEMENT OF APPLICANT

I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant Susan [signature] Date 10/24/06

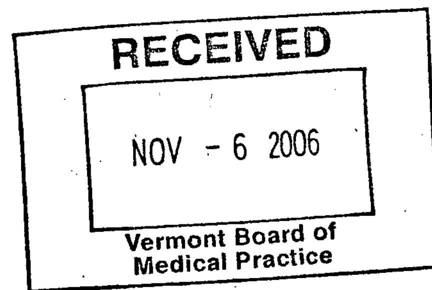
042-0005990
Susan Smith, MD
Women's Choice Gynecological Assoc.
23 Mansfield Avenue
Burlington, VT 05401

VERMONT

Department of Health
Board of Medical Practice
108 Cherry Street - P. O. Box 70
Burlington, VT 05402-0070
healthvermont.org

[phone] 802-657-4220
[toll free] 800-745-7371
[fax] 802-657-4227

Agency of Human Services



Date: October 27, 2006

Dear Physician:

Your 2006 Physician's License Renewal application has been received by this office and cannot be processed until the following information is received.

❑ $450 renewal fee

Application

Part I
- ❑ Item 1
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- ❑ Item 3
- ❑ Item 4
- ❑ Item 5
- ❑ Item 6
- ❑ Item 7
- ❑ Item 8

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- ❑ Item 20

Part III
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- ❑ Item 22
- ❑ Item 23
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- ❑ Item 25

Part IV
- ❑ Item 26
- ❑ Item 27
- ☑ Item 28
- ❑ Item 29
- ❑ Item 30A
- ❑ Item 30B
- ❑ Item 31A
- ❑ Item 31B
- ❑ Item 32
- ❑ Item 33
- ❑ Item 34
- ❑ Item 35
- ❑ Item 36
- ❑ Item 37A
- ❑ Item 37B
- ❑ Item 38
- ❑ Item 39
- ❑ Item 40
- ❑ Item 41
- ❑ Item 42A
- ❑ Item 42B

Part V
- ❑ Date
- ❑ Signature

Child Support, Taxes, Unemployment Compensation Statement
- ❑ Number 1 – check one of the two statements
- ❑ Number 2 – check one of the two statements
- ❑ Number 3 – check one of the three statements

Completed Form A
- ❑ Completed form

The page(s) that needs completion (if applicable) is attached. Please complete the necessary item, initial, date and return as soon as possible so that processing may be finalized.

Thank you.

Sincerely,

Medical Practice Board
(802) 657-4220 or (800) 745-7371

Enclosures