Pd

INVOICE

VERMONT BOARD OF MEDICAL PRACTICE
SECRETARY OF STATE'S OFFICE
PAVILION OFFICE BUILDING
MONTPELIER, VT 05609-1106

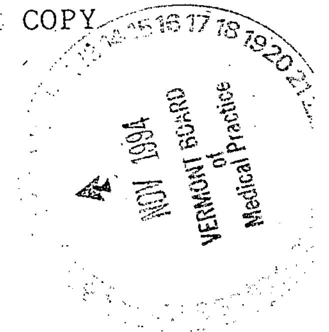
DATE: October 24, 1994

BILL TO: Susan Fay Smith
University Assoc. in OB/GYN
Blair Park
Williston, VT 05495

LICENSE VERIFICATION FOR PHYSICIAN:	REQUESTING STATE/ ORGANIZATION	$20.00 PER VERIFICATION
Yourself	New Hampshire	$20.00

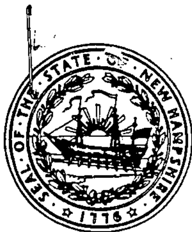
TOTAL AMOUNT OF BILL: $20.00

PLEASE MAKE CHECKS PAYABLE TO SECRETARY OF STATE AND ENCLOSE A COPY OF THIS INVOICE FOR PROPER CREDITING.



PLEASE REMIT TO: Attention: Debbie Morehouse
VT Board of Medical Practice
109 State Street
Montpelier, VT 05609-1106

**IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT DEBBIE MOREHOUSE (802) 828-2673.



State of New Hampshire

BOARD OF REGISTRATION IN MEDICINE

2 INDUSTRIAL PARK DRIVE
CONCORD, NH 03301

TDD Access: Relay NH 1-800-735-2964

TEL. (603) 271-1203

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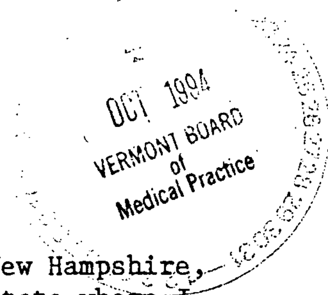

RESPONSIBILITY OF APPLICANT

CLEARANCE FROM OTHER STATE BOARDS

In applying for a license to practice medicine in the State of New Hampshire, the Medical Board requires that this form be completed by each state where I hold licensure. This is your authority to release any information in your files, favorable or otherwise, directly to the Board of Registration in Medicine, 2 Industrial Park Drive, Concord, New Hampshire 03301. Your early attention in this matter is appreciated.

Susan Fay Smith
(Signature)

Susan Fay Smith
(Please type your name)

VT LICENSE 5990

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(To be completed and returned by other State Board)

STATE OF: Vermont

FULL NAME OF LICENSEE: Susan Fay Smith, M.D.

LICENSE NUMBER: 42-0005990

IS LICENSE CURRENT?: Yes

IN GOOD STANDING?: Yes

(BOARD SEAL)

Janice E Fifield
(Signature)

Staff Assistant
(Title)

October 24, 1994
(Date)

Hayes, Tracy

From: Green, Julie on behalf of medicalboard
Sent: Friday, December 10, 2010 7:46 AM
To: Hayes, Tracy
Subject: FW: change of address

Vermont Board of Medical Practice
108 Cherry Street
P.O. Box 70
Burlington, VT 05402
(*physical address: 101 Cherry Street 3rd Floor*)
-----Original Message-----
From: susan smith [mailto:susansathome@hotmail.com]
Sent: Thursday, December 09, 2010 11:15 AM
To: medicalboard
Subject: change of address

Good morning. I have a change of address:

email: ssmith@VTGyn.com

street address:

Susan F.Smith, M.D.
Vermont Gynecology
1775 Williston Road
South Burlington, Vermont 05403

Thank you

Susan F.Smith, M.D.
License Number: 042-0005990

PA
#20

Medilert-IRIS™
Division of The Castlemark Corp.
P.O. Box 14050
Scottsdale, AZ 85267-4050

PH. 800-846-1351
FAX 800-765-4814

VT-250

July 19, 1995

Vermont Board of Medical Practice
109 State Street
Montpelier VT 05609-7866
ATTN: LICENSE VERIFICATION

RE: **SMITH, Susan F., MD**
LICENSE #: 5990

Dear Sir/Madam:

The above named individual has submitted an application to MEDILERT-IRIS for processing. As part of the credentialing process, we are requesting verification of this individual's claimed licensing. We have enclosed appropriate data regarding this individual as well as a photocopy of a signed release.

A self-addressed stamped envelope has been enclosed for your convenience.

Sincerely,

Sheila Bezok

Sheila Bezok, VT-250
Administrative Assistant

VERIFICATION:

1. Provider's License Number: 42-5990
2. Issuance date: July 14, 1977
3. Expiration Date: November 30, 1996
4. Is there a record of any license suspension, restriction or revocation regarding this provider? Yes______ No ✓

If yes, please explain: ____________________

Debbie Morehouse — Signature / Title
8-8-95 — Date

Administrative Assistant

I, Susan Jay Smith, do hereby grant to Planned Parenthood Federation of America, Inc., and its affiliates, and/or their agents, permission to gain access to, inspect and duplicate any and all information, records, summaries or records and statistical reports (including physician utilization profiles pertinent to my provision of medical services and my medical professional qualifications) currently on file at any and all acute care facilities, skilled nursing facilities, outpatient centers and any other institutional settings with which I am or have been affiliated; any local county, state and federal medical trade association, accrediting organization, medical society or governmental entity.

I hereby release Planned Parenthood Federation of America, Inc., and its affiliates, employees, and/or its authorized agents, from any and all liability or expense which is incurred by Planned Parenthood Federation of America, Inc., its affiliates, employees or its authorized agents, due to the release of any of the information described in this Provider Application to any purchaser of health care services or to any representatives of local, state and federal governmental agencies.

I agree to immediately notify the Planned Parenthood affiliate with whom I am associated, upon termination, suspension or denial of my malpractice insurance. I also agree to immediately notify the Planned Parenthood affiliate with whom I am associated upon termination, suspension or revocation of my staff privileges at any hospital or health care facility.

Signature of Clinician: Susan Smith Date: 6/15/95

This authorization is valid for 24 months from the date shown above.
A photocopy shall be considered as valid as the original.