



STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE ONE OF SIX



I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/92 to 11/30/94. TWO YEAR RENEWAL FEE: \$205.
Enclose a check in the amount of \$205. made payable to the Vermont Board of Medical Practice.

42-0006255 A
Edd, Gilbert Lyon MD
140 Hospital Drive
Bennington VT 05201

Important:

- Please print legibly or type your answers.
- Answer all questions (front and back of each page) completely-it is not adequate to state that the Board already has the information. Use the enclosed Form A to provide explanations to "yes" answers in Section II.
- Make a copy of this form and all attachments for your own records.
- Do not delegate this important task to an employee, as false statements on this form are grounds for unprofessional conduct.
- Thank you for your cooperation.

SECTION I

1. Name: EDD G. LYON 2. Vermont License Number: 42- 0006255

3. Other Name(s), if any, under which you were licensed in Vermont and elsewhere:

4. Home Address: RICE LANE

City, State, Zip Code: BENNINGTON, VT. 05201

5. Office Address: 140 HOSPITAL DR. B

City, State, Zip Code: BENNINGTON, VT. 05201

6. Daytime Telephone Number: Area Code: (802) 447-1191

7. Date of Birth: Month: 12 Day: 20 Year: 46

8. Place of Birth: TULSA, OKLA. 9. Sex: Male Female

10. Licensing Examination Taken - Check: National Boards FLEX
 State Examination-Identify State: _____ Other Examination Specify: _____

11. Undergraduate Degree - Circle: (B.A.) B.S. A.B. Other: _____ Year of Graduation: 1969

Degree Granting Institution: HAMILTON COLLEGE Location: CLINTON, N.Y.
First Institution (If transfer): _____ Location: _____

12. Medical Degree - Circle: (M.D.) Other: _____ Year of Graduation: 1975

Degree Granting Medical School: ALBANY MED. COLLEGE Location: ALBANY, N.Y.

First Medical School (If transfer): UNIVERSIDAD AUTONOMA Location: GUADALAJARA, MEXICO



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13. Do you have hospital privileges in Vermont? Yes No

Name(s) and Location(s) of Hospital(s): _____

SOUTHWESTERN VT. MEDICAL CENTER
BENNINGTON, VT.

14. Did you practice in Vermont during the past 12 months? Yes No

15. Other states where you now hold an active license to practice: _____

16. States where you previously were licensed to practice: OKLAHOMA

17. Please list your specialty(ies) and indicate if you are American specialty board certified in those specialties:
Specialty(ies) & Subspecialty(ies) American Specialty Board Certified (Yes or No)

- * (a) FAMILY PRACTICE Yes No Year Certified/Recertified: 78, 90
- (b) _____ Yes No Year Certified/Recertified: /
- (c) _____ Yes No Year Certified/Recertified: /

18. Please list the postgraduate educational degrees that you have earned related to your practice:

Institution	City	State	Degree	Year
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(a) ALBANY MEDICAL COLLEGE ALBANY N.Y. MD 1975

(b) _____

19. Please list the institutions where you have had residency or fellowship training:

Institution	City	State	Specialty	Year Completed
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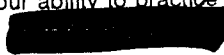
(a) UNIV. OF OKLA. TULSA OKLA. FAMILY PRAC. 1978


(b) _____

(c) _____


SECTION II: PLEASE CHECK YES OR NO.


A "YES" ANSWER REQUIRES AN EXPLANATION ON THE ENCLOSED FORM A.

1. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine, resident or fellow? 

2. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine, resident or fellow? 

3. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses? YES NO

4. Are you currently under investigation for a criminal act? 

5. Are you now, or have you been in the past, dependent upon alcohol or drugs? 



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SECTION II CONTINUED

6. 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
7. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim/complaint/demand for damages)? YES NO
8. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, resigned from a medical staff in lieu of disciplinary action or resigned from a medical staff after a complaint or peer review action has been initiated against you? YES NO
9. Have you ever voluntarily surrendered or resigned a license to practice medicine or any healing art? YES NO
10. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered by any jurisdiction or federal agency at any time? YES NO
11. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill? YES NO
12. Have you ever withdrawn an application for a medical license or been denied a medical license for any reason? YES NO
13. Have you ever been turned down for coverage by a malpractice insurance carrier? YES NO
14. Have you ever been notified as a responsible party of a Severity Level III quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? YES NO
15. To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application? YES NO
16. Have you ever been dismissed or asked to leave from a residency training program(s) before completion? YES NO

SECTION III - TO BE COMPLETED ONLY BY PHYSICIANS PRACTICING IN VERMONT

1. Current Status (please check one): Active Retired* Other (please explain) _____
*Note: If you are retired or are not practicing in Vermont, you need not complete SECTION III; however you must complete SECTION IV.

2. Postgraduate training in Vermont:

Are you currently in a postgraduate training program in Vermont as a resident or clinical fellow? Yes No
If you are in a Vermont program, are you a Resident Clinical Fellow Research Fellow?
How many hours per typical week do you spend in this Vermont postgraduate training program? _____ hrs./wk. in Vermont.

3. What is the date you started practicing medicine (excluding residency or fellowship training)?
(Month/Year) 8/178

4. What is the date you started practicing medicine in Vermont (excluding residency or fellowship training)?
(Month/Year) 8/178

5. Are you a staff physician involved exclusively in inpatient care or an emergency room setting? Yes No



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SECTION III CONTINUED

Instructions for completing the next portion: Please complete one "site" section for each location where you practice. Be as detailed as possible. Estimate if exact figures are not available.

The codes to be used for the Employment Setting column are as follows (if applicable, list multiple codes at one practice site):

- | | | |
|------------------------------|---|-------------------------|
| 1 Solo Practice | 6 HMO (Health Maintenance Organization) | 11 Teaching |
| 2 Group Practice | 7 Extended Care Facility | 12 Other Specify: _____ |
| 3 Community Health Center | 8 School/College Health | |
| 4 Hospital Outpatient Clinic | 9 Occupational Health | |
| 5 Hospital Inpatient | 10 Emergency Room | |

6. Practice Site Number One

Street Address: 140 HOSPITAL DR.
Town: BENNINGTON Zip: 05201

Please complete one full line for each specialty (example: pediatrics) that you practice at this site.

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?
FAMILY PRACTICE	30	2	NO	YES	30%	YES	30%	YES

Check the financial organization which best describes this site: For-profit Nonprofit
If applicable, check the type of services that you perform at this site, even if the service is not practiced as a specialty:
 Adult Medicine Pediatric Medicine Prenatal Care Gynecologic Care
 Obstetrics If you practice obstetrics, approximately how many deliveries do you perform per year at all practice sites? _____
(For example, a physician specializing in family practice who performs deliveries would check "Obstetrics".)

7. Practice Site Number Two

Street Address: 6 ROBERTS NORTH Town: RUTLAND Zip: 05701 *

Please complete one full line for each specialty that you practice at this site.

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?
GYNCOLOGY	3	3	NO	YES	15%	YES	0	YES

Check the financial organization which best describes this site: For-profit Nonprofit
If applicable, check the type of services that you perform at this site, even if the service is not practiced as a specialty: Adult Medicine Pediatric Medicine Prenatal Care Gynecologic Care
 Obstetrics If you practice obstetrics, approximately how many deliveries do you perform per year at all practice sites? _____



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SECTION III CONTINUED

8. Practice Site Number Three

Street Address: BENNINGTON COLLEGE
Town: BENNINGTON Zip: 05201
Please complete one full line for each specialty that you practice at this site.

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?
STUDENT HEALTH FAMILY PRACTICE	3	8	NO	YES	0	YES	0	YES

Check the financial organization which best describes this site: ___ For-profit Nonprofit

Check the type of services that you perform at this site, even if the service is not practiced as a specialty:
 Adult Medicine ___ Pediatric Medicine ___ Prenatal Care Gynecologic Care
___ Obstetrics If you practice obstetrics, approximately how many deliveries do you perform per year at all practice sites? _____



9. Practice Site Number Four

Street Address: _____
Town: _____ Zip: _____
Please complete one full line for each specialty that you practice at this site.

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?

Check the financial organization which best describes this site: ___ For-profit ___ Nonprofit

Check the type of services that you perform at this site, even if the service is not practiced as a specialty:
___ Adult Medicine ___ Pediatric Medicine ___ Prenatal Care ___ Gynecologic Care
___ Obstetrics If you practice obstetrics, approximately how many deliveries do you perform per year at all practice sites? _____



SECTION IV: STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
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A professional license or other authority to conduct a trade or business may not be renewed unless the licensee 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).

A professional license or other authority to conduct a trade or business may not be renewed unless the licensee 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). The maximum penalty for perjury is fifteen years in prison, a \$10,000 fine, or both.

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT

I hereby certify that I am not subject to any support order or I am subject to a support order and am in good standing with respect to or in full compliance with a plan to pay any and all child support due as of the date of this application.

OR

I hereby certify that I am NOT in good standing with respect to child support due 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" to the address below.

APPLICANT'S STATEMENT REGARDING TAXES

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 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 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" to the address below.

STATEMENT OF APPLICANT

I further certify that all information contained in this renewal application (including all pages and attachments) is true and accurate to the best of my knowledge. *Failure to provide truthful and accurate information may constitute grounds for denial of license renewal or disciplinary action.*

Social Security Number: [REDACTED]

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

Date: 10/9/92

Signature: Eld Lyon

Return the completed form and fee to:
(Return envelope enclosed)

Vermont Board of Medical Practice
109 State Street
Montpelier, Vermont 05609-1106

QUESTIONS?: (802) 828-2673 - Toll Free (Within Vermont) 1-800-439-8683 (Ask for the Medical Board)

IMPORTANT: Please be sure to write your license number on your check. Check for the correct spelling of your name and proper address on the page one label. Print any changes in the adjoining space. Sign and date the application. Enclose the correct fee of \$205.* in check or money order payable to the Vermont Board of Medical Practice.
(Medical Board Renewal Fee: \$200. + Office of Professional Regulation (OPR) Fee: \$5.00 = \$205. OPR's \$5.00 of the renewal fee represents an assessment for the Fee Limiting Subfund.)

*Note: Physicians 80 years of age or older are exempt from payment of a renewal fee; however the physician license renewal application must be completed and submitted.