Hayes, Tracy

From: Dion, Beverly [Beverly.Dion@ppnne.org]
Sent: Monday, October 03, 2011 1:26 PM
To: Hayes, Tracy
Subject: Address changes ~

Hello Tracy,

I'm writing to notify the Board of the following address changes for four of Planned Parenthood's providers:

Dr. Regan Theiler, license #: 042-0012264
As of 10/15/2011 relocating to:
128 Lakeside Ave
Suite 301
Burlington, VT 05401
448-9700 (PH)

Johanna Hauser (license #055-0030027)
Catherine Nicholas (license # 055-0030046)
Janet Young (license # 055-0030020)
As of November 1, 2011 relocating to:
183 St. Paul Street
Burlington, VT
863-6326 (ph)

Please confirm receipt of this email and let me know if you need any more information to make these changes.
Thank you,

Bev Dion

Credentialing Coordinator
Planned Parenthood of Northern New England
802.288.8432 (ph)
802.878.8001 (fax)

VERMONT

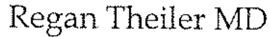
Department of Health
Board of Medical Practice
108 Cherry Street - PO Box 70
Burlington, VT 05402-0070
healthvermont.gov

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

Agency of Human Services

July 22, 2011

Regan Theiler MD



Re: Vermont Medical Licensure - **042-0012264**

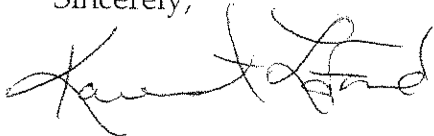
Dear Dr. Theiler:

Congratulations on receiving a license to practice medicine in Vermont. On July 20, 2011 the Vermont Board of Medical Practice granted you a Vermont medical license. Please note above. Enclosed please find your physician license and information relevant to practice in Vermont.

All medical licenses are renewed in November of every even year. You will receive a notification three months prior to the renewal date. Until that time, ***licensees have a continuing obligation to promptly notify the Board of any change or new information including, but not limited to, change of address, disciplinary or other action limiting or conditioning their license or ability to practice in any jurisdiction. Failure to do so may subject the licensee to disciplinary action by the Board.***

If you have any questions or need additional information please do not hesitate to contact the Board.

Sincerely,



Karen LaFond
Licensing Administrator
Board of Medical Practice

State of Vermont
Board of Medical Practice

THIS IS TO CERTIFY

Regan Nell Theiler MD

a graduate of The University of Wisconsin, 2003

having successfully qualified as a practitioner of medicine before this Board has been registered as provided by the Laws of the State.

Patricia A. King MD PhD

Chair: Patricia A. King, MD, PhD

License Number 042-0012264

Margaret Fink Martin

Secretary: Margaret F. Martin
Burlington
Date: July 20, 2011
Received and duly recorded.
Vermont Department of Health

Medical Doctor Application Checklist
For Office Use Only
STATE OF VERMONT - BOARD OF MEDICAL PRACTICE

Name of Applicant: Regan Nell Theiler

Mailing Address: [redacted]

Public Address: Planned Parenthood N. NE. 183 Talcott Rd Williston, VT 05495

Telephone: 802-288-8416

Date Application Received: 6/14/11

1) X FEE of $625

2) X COMPLETED APPLICATION for License to Practice Medicine in Vermont.

- X Photograph Applicant's signature required on photograph.
- X Tax & Child Support Statement Applicant's signature required
- X Statement of Good Standing
- X Release Form Applicant's signature required.

*3) X BIRTH CERTIFICATE –Must be certified Copy
Date of Birth: 10-26-1973

*4) X COPY OF MEDICAL SCHOOL DIPLOMA

*5) X MEDICAL EDUCATION DIRECT VERIFICATION
Univ of Wisconsin Madison Date: 05- -2003

6) X MEDICAL LICENSURE CERTIFICATE - Direct Verification
X TX
X GA

*7) X EXAMINATION SCORES: Direct Verification of Examination Scores:

X USMLE** ____ FLEX ____ National Boards ____ State Exam ____ LMC(

8) X AMERICAN SPECIALTY BOARD CERTIFICATE
OB/GYN (BC)

*9) X POSTGRADUATE TRAINING DIRECT VERIFICATION

Emory Univ DATES 03-07 ACGME ______

______ DATES ______ ACGME ______

______ DATES ______ ACGME ______

______ DATES ______ ACGME ______

______ DATES ______ ACGME ______

10) X Three (3) COMPLETED REFERENCE FORMS mailed directly to the Board.

X #1 Gary Hankins

X #2 Tristi Muir

X #3 Russell Snyder

11) X American Medical Association Profile Form.

☒ Verify information provided on application

*12) NA ECFMG Certificate, if International Graduate

☐ Passed/Approved

13) X National Practitioners Data Bank self-query: Applicant sends the original, unaltered response to the Board.

☐ Has applicant included everything on the application

14) NA FORM A if applicant answered yes—Refer to licensing Committee

15) X CV/Resume

16) ____ FEDERATION CHECK

*Note: FCVS Acceptance- The Board accepts certain documents (see * above) verified by the Federation of State Medical Boards' Federation Credentials Verification Service (FCVS). For more information please call 1-888-ASK-FCVS.*

Application for Physician Licensure

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name Theiler

First Name Regan

Middle Name Nell

Suffix

Maiden Name

M.D. ☒ D.O. ☐

All other names used

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website; therefore, you should consider what your preferred address is for these purposes.

Practice Address
☒ Public Access
☒ Mailing

Street Planned Parenthood Northern New England
183 Talcott Rd

City Williston State/Province VT ZIP Code 05495

Telephone 802/288-8416 Fax

E-mail address

Alternate Phone (e.g. pager or cell phone)

Home Address
☐ Public Access
☐ Mailing

Street

City

Telephone Fax

E-mail address

Alternate Phone (e.g. pager or cell phone)

Applicant Name: Regan Theiler Date: 5/7/11

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

10/26/1973	Osseo	WI	USA
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F	[redacted]	1609069558	
Gender	Social Security Number	NPI Number	Are you a U.S. Citizen? ☒ Yes ☐ No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. *For more information on the NPI , please go to http://www.cms.hhs.gov/NationalProvIdentStand/.*

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School (attach additional pages if necessary)

1. School Name University of Wisconsin Madison
   Address 1300 University Ave
   City Madison State/Province WI ZIP Code 53703
   Country USA
   Attendance Dates (From – To) 1996- 2003
   Graduation Date May 2003 Degree MD, PhD

2. School Name
   Address
   City State/Province ZIP Code
   Country
   Attendance Dates (From – To)
   Graduation Date Degree

Applicant Name: Regan Theiler Date: 6/7/11

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

1. Medical School Name ______________________________

Address ______________________________

City ______________ State/Province ______________ ZIP Code ______________

Country ______________________________

Attendance Dates (From – To) ______________________________

Graduation Date ______________ Degree ______________

2. Medical School Name ______________________________

Address ______________________________

City ______________ State/Province ______________ ZIP Code ______________

Country ______________________________

Attendance Dates (From – To) ______________________________

Graduation Date ______________ Degree ______________

Applicant Name: Regan Theiler Date: 6/7/11

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. Additionally, the postgraduate program must provide this Board with the Program Director's recommendation letter. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training (copy and attach additional pages if necessary)

Complete name and address of hospital where training was conducted (Do Not Abbreviate)

1.Hospital Name Emory University School of Medicine
Hospital Address 69 Jesse Hill Jr Drive
City Atlanta
State/Province GA
ZIP Code 30303
Country USA

PGY: (e.g., 1, 2, 3, etc.) 1-4 ☒ Internship ☒ Residency ☐ Fellowship ☐ Research ☐ Other
Accredited by: ☒ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other
Department/Specialty: Obstetrics + Gynecology

From: 7 / 2003 To: 6 / 2007 Successfully Completed? Yes ☒ No ☐ In Progress ☐
Month Year Month Year

2.Hospital Name
Hospital Address
City
State/Province
ZIP Code
Country

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other
Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other
Department/Specialty:

From: / To: / Successfully Completed? Yes ☐ No ☐ In Progress ☐
Month Year Month Year

Applicant Name: Regan Theiler Date: 6/7/11

6. Postgraduate Training (continued)

3. Hospital Name ______

Hospital Address ______

City ______

State/Province ______

ZIP Code ______

Country ______

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other ______

Department/Specialty: ______

From: ____ / ____ To: ____ / ____ Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

4. Hospital Name ______

Hospital Address ______

City ______

State/Province ______

ZIP Code ______

Country ______

PGY: (e.g., 1, 2, 3, etc.) ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other

Accredited by: ☐ ACGME ☐ AOA ☐ RCPSC ☐ None ☐ Other ______

Department/Specialty: ______

From: ____ / ____ To: ____ / ____ Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

Applicant Name: Regan Theiler Date: 6/7/11

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below.

Examination	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)	Number of attempts
State Board Exam ______ (State)		☐ P ☐ F	
FLEX Pre-1985		☐ P ☐ F	
FLEX Component 1		☐ P ☐ F	
FLEX Component 2		☐ P ☐ F	
LMCC – Single		☐ P ☐ F	
LMCC – Part I		☐ P ☐ F	
LMCC – Part II		☐ P ☐ F	
NBME Part I		☐ P ☐ F	
NBME Part II		☐ P ☐ F	
NBME Part III		☐ P ☐ F	
SPEX		☐ P ☐ F	
NBOME Part I		☐ P ☐ F	
NBOME Part II		☐ P ☐ F	
NBOME Part III		☐ P ☐ F	
COMLEX-USA Level 1		☐ P ☐ F	
COMLEX-USA Level 2, CE		☐ P ☐ F	
COMLEX-USA Level 2, PE		☐ P ☐ F	
COMLEX-USA Level 3		☐ P ☐ F	
COMVEX		☐ P ☐ F	
USMLE Step I	10/1998	☒ P ☐ F	1
USMLE Step II, CS	4/2003	☒ P ☐ F	1
USMLE Step II, CK		☐ P ☐ F	
USMLE Step III	10/2004	☒ P ☐ F	1

Applicant Name: Regan Theiler Date: 6/7/11

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG website at www.ecfmg.org.

8. ECFMG (if applicable)

Certificate Number ____________ Issue Date ____________ Valid Through Date ____________

9. State/Province Professional Licensure whether temporary or permanent: List all states and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license or certification. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states or provinces in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure – MD or DO only – attach additional pages if necessary

	State/Province	Type (MD, DO)	License Number	Status	Issue Date
1.	TX	MD	M6911	Active	7/25/07
2.	GA	MD	000305	Inactive	7/1/03
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Applicant Name: Regan Theiler Date: 6/7/11

All Other Health Care Licensure/Certification (e.g., RN, PA, etc.) - attach additional pages if necessary.

1. State/Province ______ Type ______ License Number ______ Status ______ Issue Date ______
2. State/Province ______ Type ______ License Number ______ Status ______ Issue Date ______
3. State/Province ______ Type ______ License Number ______ Status ______ Issue Date ______
4. State/Province ______ Type ______ License Number ______ Status ______ Issue Date ______
5. State/Province ______ Type ______ License Number ______ Status ______ Issue Date ______

10. Chronology of Activities: List ALL activities (medical, non-medical and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: Month: July Year: 2007 To: Month: June Year: 2011	Practice/Employment Name University of Texas Medical Branch (or list non-working time as indicated above) Practice/Employment Address 301 University Blvd City Galveston State/Province TX ZIP Code 77555-0587 Country USA Position and Department Ob/Gyn % Clinical 25 % Administrative 75 Employment ☒ Staff Privileges ☐ Affiliation ☐ Other ______
2. From: Month: ______ Year: ______ To: Month: ______ Year: ______	Practice/Employment Name ______ (or list non-working time as indicated above) Practice/Employment Address ______ City ______ State/Province ______ ZIP Code ______ Country ______ Position and Department ______ % Clinical ______ % Administrative ______ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other ______

Applicant Name: Regan Theiler Date: 6/7/11

Dates: From/To	Practice/Employment
3. From: Month: ______ Year: ______ To: Month: ______ Year: ______	Practice/Employment Name ______ (or list non-working time as indicated above) Practice/Employment Address ______ City ______ State/Province ______ ZIP Code ______ Country ______ Position and Department ______ % Clinical ______ % Administrative ______ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other ______
4. From: Month: ______ Year: ______ To: Month: ______ Year: ______	Practice/Employment Name ______ (or list non-working time as indicated above) Practice/Employment Address ______ City ______ State/Province ______ ZIP Code ______ Country ______ Position and Department ______ % Clinical ______ % Administrative ______ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other ______
5. From: Month: ______ Year: ______ To: Month: ______ Year: ______	Practice/Employment Name ______ (or list non-working time as indicated above) Practice/Employment Address ______ City ______ State/Province ______ ZIP Code ______ Country ______ Position and Department ______ % Clinical ______ % Administrative ______ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other ______
6. From: Month: ______ Year: ______ To: Month: ______ Year: ______	Practice/Employment Name ______ (or list non-working time as indicated above) Practice/Employment Address ______ City ______ State/Province ______ ZIP Code ______ Country ______ Position and Department ______ % Clinical ______ % Administrative ______ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other ______

Applicant Name: Regan Theiler Date: 6/7/11

11. Malpractice Liability Claims Information (copy this form to report multiple claims)

Name of patient involved: ____________________

In which state did the action take place? __________ Case number (if applicable) ____________________

Which court? ____________________
(If private compromise or settled before initiation of civil action, state here)

Current status of claim: ____________________

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out)
☐ Other ____________________

Amount of judgment or settlement $ __________ Amount paid on your behalf $ __________

Month and year of event precipitating claim: ____________________

Month and year of lawsuit: ____________________

Insurance carrier at time: ____________________

What is/or was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other __________

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Applicant Name: Theiler, Regan Date: 6/8/11

Addendum 1
Application for License to Practice Medicine in Vermont
Physician – Medical Doctor

1. Were you in active clinical practice in the past 12 months? X Yes ____ No

2. Years of Practice [See 26 VSA § 1368(a)(10)]
Month and year you started practicing as a physician (excluding residency/fellowship training)?
8/2007

3. Have you ever held a Vermont Limited Temporary License: ____ Yes X No
If yes, License Number: ____________________

4. Premedical Education
Please provide the names of premedical schools you attended and the dates of attendance.

Name and location of institution	Degree	From	To
DePaul University, Chicago IL	B.S.	1992	1996

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

5. Specialty Board Certification
Enter up to three specialty codes from the ***Specialty Codes List*** on Instructions page 3. List your primary specialty first. If you cannot locate a specialty, please write the specialty name in the space provided.

Specialty Code				Specialty Name (if code unknown)	Name of Board	Board Certified	Year Certified	Year Recertified
1	1	0	1		Ob/Gyn	☒ yes ☐ no	2009	
						☐ yes ☐ no		
						☐ yes ☐ no		

6. Practice
Do you have hospital privileges? X Yes ____ No
List all hospitals where you have, or previously have had, staff privileges. Include name, address, and dates.

Name	Address	From/To	Specialty/Subspecialty
UTMB	Galveston, TX	8/2007 - 6/2011	Ob/Gyn
Mainland Medical Center	Texas City TX	9/2008 - 6/2011	Ob/Gyn

Statutory Profile Questions

Vermont law, 26 VSA § 1368, creates a data repository within the Department of Health. Under this law, the Department must collect certain information to create individual profiles on all health care professionals licensed, certified, or registered by the Department pursuant to Title 26 of the VSA. Please try to answer the following questions as best as you can. You will receive a copy of your profile prior to its initial release to the public and each time the profile is modified or amended. You will be given a reasonable time to correct factual inaccuracies that appear in such profile. As noted below, certain questions do not need to be answered.

It is very important for us to receive photostatic copies of court papers, licensing authority decisions, and other documents relevant to the questions below in order to have a true and accurate description of actions taken.

7. Criminal Convictions [See 26 VSA § 1368(a)(1)]

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. For purposes of this question, "convicted" means that you pleaded guilty or that you were found or adjudged guilty by a court of competent jurisdiction. Please provide copies of papers fully documenting the convictions.

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

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

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

8. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]

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 finding by a court of competent jurisdiction. Please provide copies of papers fully documenting these matters.

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

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

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

9. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)]

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.

(Date) (Final Disposition – Summary)

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

10. Licensing Authority Matters in Other States [See 26 VSA § 1368(a)(4)]

Please provide a description of all formal charges served by licensing authorities of other states, the findings, conclusions, and orders of such licensing authorities, and final disposition of such matters by the courts, if appealed, in those states. Please provide copies of papers fully documenting these matters.

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

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

11. Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)]

A. Revocation/Involuntary Restrictions

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. Please provide copies of papers fully documenting these matters.

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

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

B. Other Restrictions

Please provide a description of all resignations from, or nonrenewal 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. Please provide copies of papers fully documenting these matters.

(Date)	(Hospital)	(State)

(Nature of Action)	(Action)	(Reason for Action)

☐ In Lieu ☐ In Settlement

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

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

Note: Answering #12 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

Please provide information about your appointments to medical school or professional school faculties.

(School)	(City)	(State)	(Nature of Appointment)	From (year) To (year)
UTMB	Galveston	TX	Assistant Professor	2007 - 2011

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

B. Teaching

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years.

(School/Institution)	(City)	(State)	(Nature of Teaching)	From (year) To (year)
UTMB	Galveston	TX	Ob/Gyn Residents	2007 - 2011

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

13. Publications [See 26 VSA § 1368(a)(13)]

Note: Answering #13 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

(Title) (Publication) (Year)

(Title) (Publication) (Year)

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

14. Activities [See 26 VSA § 1368(a)(14)]

Note: Answering #14 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your professional or community service activities and awards.

(Activities or Awards)

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

15. Interview

A. In which part of Vermont would you prefer to be interviewed? Northern-Burlington/St. Albans area, Southern-Rutland, Springfield, Central-Montpelier/Randolph, or using webcam (Please be specific)?

Northern

B. When are you scheduled to begin work in Vermont? 8/1/11

C. What is going to be the primary location of your practice setting? Planned Parenthood - Burlington

D. Provide a brief description of your anticipated practice: medical director - all planned parenthood clinics in VT, NH, ME

E. What has been your physical residence (city, state) in the past ten years?

Galveston, TX 2007 - 20011. Atlanta, GA 2003 - 2007

Madison, WI ~~200~~ 1996 - 2003

Addendum 2

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

16. Have you ever applied for and been denied a license to practice medicine or any other healing art? ______Yes__X__No

17. Have you ever withdrawn an application for a license to practice medicine or any other healing art? ______Yes__X__No

Withdrawal or denial of License – Attach documents

State____Year______________

Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated______________

____

____

18. Have you ever voluntarily surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action or for any other reason? ______Yes__X__No

Voluntarily surrendered or resigned a license to practice medicine or any healing art – Attach documents

State____Year______________

Circumstances____

____

____

19. 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__X__No

Disciplinary charges or action – Attach documents

Name of organization involved______________________________Date______________

Duration____

Action taken (circle all that apply)

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

Circumstances____

____

____

____

20. Have you ever been denied the privilege of taking an examination before any state medical examining board? _____Yes __X__No

Denial of examination privileges – Attach documents

State____

Circumstances under which examination privileges denied____

____

____

21. Have you ever discontinued your education, training, or clinical practice for a period of more than three months? NOT including premedical education. _____Yes __X__No

If yes, Please explain:____

____

____

22. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion? _____Yes __X__No

Residency Training Program(s) not completed – discontinued education, training, practice – Attach documents

Residency Training Program(s)____

Location of Programs_______________________________Year_______________

Circumstances____

____

____

____

23. 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 __X__No

Affecting Health Care Institution Staff Privileges, Employment or Appointment – Attach documents

Institution Involved____

Location_______________________________Year_______________

Circumstances____

____

24. 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 __X__No

Privilege to prescribe controlled substances – Attach documents

Name of organization involved____

Type of restriction_______________________________Date_______________

Circumstances of restriction____

____

____

____

____

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

Court____

City and State____

Charge____

Description____

____

____

Status____

____

Date______________________

26. Do you currently or have you ever prescribed any prescription medication over the Internet? This does NOT include prescribing you would do using electronic medical records in your practice. ______Yes__X__No

Please provide a general description of your practice of Internet prescribing____

____

____

27. Medical Malpractice Court Judgments/Settlements [See 26 VSA § 1368(a)(6A)]

A. Judgments

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases; complete the below information and provide copies of papers fully documenting these matters.

☐ Judgment ☐ Arbitration

____

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

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

B. Settlements

Please provide a description of all pending settlements and settlements of medical malpractice claims against you.

Please complete the below information and provide copies of papers fully documenting these matters.

____

(Date) (Court) (State) (Amount Assessed Against You)

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

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

____

____

____

Addendum 3

Return this form to the Board along with the completed application.
This information is confidential and is exempt from public disclosure.

28. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged? ____Yes __X__ No

Criminal Investigation – Proceeding – Attach documents

Court____

City and State____

Charge____

Description____

____

____

____

____

____

____

____

____

Status____

____

Date____________________

29. To your knowledge, are you the subject of an investigation by any other licensing board under which you have not been charged as of the date of this application? ____Yes __X__ No

Investigation by any other licensing board – Attach documents

Name of Licensing Board________________________________ Date____________________

Location of Licensing Board____

Circumstances____

MEDICAL QUESTIONS

Please answer "Yes" or "No" to the questions below. Definitions are provided to assist you in answering. Please explain any "Yes" answers.

DEFINITIONS

In answering the questions above, please use these definitions:

"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.

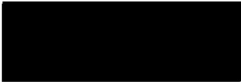
"**Currently**" – This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"**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.

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



In explaining a "Yes" answer, 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.

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

In explaining a "Yes" answer, 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.

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

In explaining a "Yes" answer, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

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____________

Addendum 4

List of Three (3) References

List a total of three (3) references in the space below. The individuals listed must be a fully licensed physician attesting to your character and professional abilities. Return this sheet to the Board with your application.

Make three (3) copies of the attached Reference Form (Addendum 4A) and mail a copy to each individual listed below, along with a copy of the signed Affidavit and Authorization for Release of Information (UA Page 11). All completed Reference forms must be returned directly to the Board.

***NOTE**: Program Director should be substituted for Chief of Service for applicants who are applying for a license while still in residency training or have completed a residency within the last year.

Reference #1: Chief of Service (See Program Director Note* above):

Name: Gary D.V. Hankins
Address: 301 University Blvd
City, State, Zip: Galveston TX 77555-0587
Telephone: (409) 772-6803
How long and at what capacity has this individual known you? 4 yrs, Department Chair

Reference #2: Active physician staff member at the hospital where you have a current or recent appointment:

Name: Tristi Muir
Address: 301 University Blvd
City, State, Zip: Galveston TX 77555-0587
Telephone: (409) 772-2610
How long and at what capacity has this individual known you? 4 yrs, Colleague

Reference #3: Active physician staff member at the hospital where you have a current of recent appointment:

Name: Russell Snyder
Address: 301 University Blvd
City, State, Zip: Galveston TX 77555-0587
Telephone: (409) 772-5051
How long and at what capacity has this individual known you? 4 yrs, Division Director

NOTE: If you are unable to provide references from these individuals because you have never held hospital privileges, attach such an explanation to this form when you submit your application. Three other references from physicians you have worked with most recently will then be required.

Addendum 5

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 of Hardship".

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business shall 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 and payable and all returns have been filed, 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 taxed would impose an unreasonable hardship (32 V.S.A. § 3113).

2. You must check on of the two statements below regarding taxes:
   - [x] 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 of 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 contribution:
   - [x] I hereby certify, under the pains of 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 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 of Hardship".

   -OR-

   - [ ] 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 Number: [redacted] Date of Birth: 10 / 26 / 73

*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: [signature] Date: 6/7/11

Addendum 6

Consent to Disclosure of Prescriber-Identifiable Information for Marketing or Promoting Prescription Drugs

Under Vermont law, a prescriber may give consent so that his or her identifiable data in prescription drug records may be used for marketing or promoting prescription drugs. If a prescriber chooses not to consent, the use of prescriber-identifiable data in prescription drug records is restricted as provided for in the law. The text of the law is found at 18 V.S.A. § 4631, and a copy of the law appears on the next page.

If you choose to consent to the use of your identifiable data in prescription drug records for marketing or promoting prescription drugs, please check the "I consent" box below and sign next to it. Your consent is effective for this licensing or certification period.

If you wish not to consent, you do not need to complete this consent form.

If you do complete this form, please return it to the Board of Medical Practice with your completed license or certification application of renewal form.

You may revoke your consent at any time by signing the Revocation of Consent form and sending it to the Board of Medical Practice. The Revocation form may be obtained directly from the Board or on the Board's website.

☐ I consent ______________________________ ____________________

Signature Date

______________________________ ____________________

Print Name Vermont License or Certification Number

Mailing Address (please print): ____

____

____

____

Telephone Number: ____

The Vermont Statutes Online

Title 18: Health

Chapter 91: Prescription Drug Cost Containment

4631. Confidentiality of prescription information

§ 4631. Confidentiality of prescription information

(a) It is the intent of the general assembly to advance the state's interest in protecting the public health of Vermonters, protecting the privacy of prescribers and prescribing information, and to ensure costs are contained in the private health care sector, as well as for state purchasers of prescription drugs, through the promotion of less costly drugs and ensuring prescriber's receive unbiased information.

(b) As used in this section:

(1) "Electronic transmission intermediary" means an entity that provides the infrastructure that connects the computer systems or other electronic devices used by health care professionals, prescribers, pharmacies, health care facilities and pharmacy benefit managers, health insurers, third-party administrators, and agents and contractors of those persons in order to facilitate the secure transmission of an individual's prescription drug order, refill, authorization request, claim, payment, or other prescription drug information.

(2) "Health care facility" shall have the same meaning as in section 9402 of this title.

(3) "Health care professional" shall have the same meaning as in section 9402 of this title.

(4) "Health insurer" shall have the same meaning as in section 9410 of this title.

(5) "Marketing" shall include advertising, promotion, or any activity that is intended to be used or is used to influence sales or the market share of a prescription drug, influence or evaluate the prescribing behavior of an individual health care professional to promote a prescription drug, market prescription drugs to patients, or evaluate the effectiveness of a professional pharmaceutical detailing sales force.

(6) "Pharmacy" means any individual or entity licensed or registered under chapter 36 of Title 26.

(7) "Prescriber" means an individual allowed by law to prescribe and administer prescription drugs in the course of professional practice.

(8) "Promotion" or "promote" means any activity or product the intention of which is to advertise or publicize a prescription drug, including a brochure, media advertisement or announcement, poster, free sample, detailing visit, or personal appearance.

(9) "Regulated records" means information or documentation from a prescription dispensed in Vermont and written by a prescriber doing business in Vermont.

(c)(1) The department of health and the office of professional regulation, in consultation with the appropriate licensing boards, shall establish a prescriber data-sharing program to allow a prescriber to give consent for his or her identifying information to be used for the purposes described under subsection (d) of this section.

The department and office shall solicit the prescriber's consent on licensing applications or renewal forms and shall provide a prescriber a method for revoking his or her consent. The department and office may establish rules for this program.

(2) The department or office shall make available the list of prescribers who have consented to sharing their information. Entities who wish to use the information as provided for in this section shall review the list at minimum every six months.

(d) A health insurer, a self-insured employer, an electronic transmission intermediary, a pharmacy, or other similar entity shall not sell, license, or exchange for value regulated records containing prescriber-identifiable information, not permit the use of regulated records containing prescriber-identifiable information for marketing or promoting a prescription drug, unless the prescriber consents as provided in subsection (c) of this section. Pharmaceutical manufacturers and pharmaceutical marketers shall not use prescriber-identifiable information for marketing or promoting a prescription drug unless the prescriber consents as provided in subsection (c) of this section.

(e) The prohibitions set forth in subsection (d) of this section shall not apply to the following:

(1) the sale, license, exchange for value, or use, of regulated records for the limited purposes of pharmacy reimbursement, prescription drug formulary compliance; patient care management; utilization review by a health care professional, the patient's health insurer, or the agent of either; or health care research;

(2) the dispensing of prescription medications to a patient or to the patient's authorized representative;

(3) the transmission of prescription information between an authorized prescriber and a licensed pharmacy, between licensed pharmacies, or that may occur in the event a pharmacy's ownership is changed or transferred;

(4) care management educational communications provided to a patient about the patient's health conditions, adherence to a prescribed course of therapy and other information relating to the drug being dispensed, treatment options, recall or patient safety notices, or clinical trials;

(5) the collection, use, or disclosure of prescription information or other regulatory activity as authorized by chapter 84, chapter 84A, or section 9410 of this title, or as otherwise provided by law;

(6) the collection and transmission of prescription information to a Vermont or federal law enforcement officer engaged in his or her official duties as otherwise provided by law; and

(7) the sale, license, exchange for value, or use of patient and prescriber data for marketing or promoting if the data do not identify a prescriber, and there is no reasonable basis to believe that the data provided could be used to identify a prescriber.

(f) In addition to any other remedy provided by law, the attorney general may file an action in superior court for a violation of this section or of any rules adopted under this section by the attorney general. The attorney general shall have the same authority to investigate and to obtain remedies as if the action were brought under the Vermont consumer fraud act, chapter 63 of Title 9. Each violation of this section or of any rules adopted under this section by the attorney general constitutes a separate civil violation for which the attorney general may obtain relief. (Added 2007, No. 80, § 17; amended 2007, No. 89 (Adj. Sess), § 3, eff. March 5, 2008.)

State of Vermont
Department of Health
Board of Medical Practice

Statement of Good Standing

Regarding Any Unpaid Judgment Issued by the Judicial Bureau or District Court for Fines or Penalties for a Violation or Criminal Offense

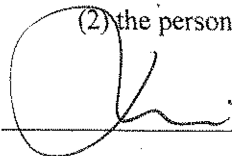
I hereby state that I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

I understand that a license may not be issued or renewed without such a statement.

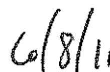
I further understand that, for the purposes of this section, a person is in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense if:

(1) 60 days or fewer have elapsed since the date a judgment was issued; or

(2) the person is in compliance with a repayment plan approved by the judiciary.



Signature



Date

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) *passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.*

JUN 13 2011

Affidavit
And
Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

[signature]
Applicant's Signature (must be signed in the presence of a notary)

Theiler
Applicant's Printed Last Name

Regan N
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

6/8/11
Date of Signature

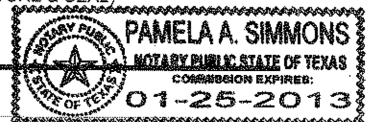
NOTARY

Dated 6/8/11 Signed Pam Simmons

State of Texas County of Galveston

SUBSCRIBED AND SWORN TO before me this 8th day of, June 2011.

My commission expires: 1-25-2013 (NOTARY PUBLIC SIGNATURE & SEAL)



Applicant Name: Theiler, Regan Date: 6/8/11

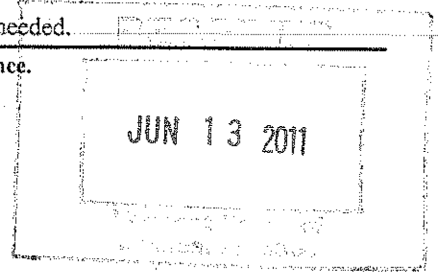
Uniform Application for Physician State Licensure

© 2008 Federation of State Medical Boards

Addendum 4A

Reference Form

Substitute forms are not acceptable. This form may be duplicated as needed.



This form is to be completed by the individual providing the reference.
Please return the completed form directly to the Board at:

Vermont Department of Health
Board of Medical Practice
108 Cherry Street, P.O. Box 70
Burlington, VT 05401

Name of Applicant: Regan Theiler

The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. Thank you for your cooperation.

Please complete all parts of this form. If more room is needed, please attach additional information.

Dr. Theiler was at UTMB, Galveston

From July, 2007 to July, 2011. During that time, he/she was (List status in the Institution): faculty

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

Category	Poor	Fair	Average	Above Average
Basic medical knowledge:				✓
Professional judgment:				✓
Sense of responsibility:				✓
Moral character/ ethical conduct:				✓
Competence and skill:				✓
Cooperativeness, ability to work with others:				✓
History & physical exam taking:				✓
Record keeping:				✓
Case presentations:				✓
Patient management:				✓
Physician-Patient Relationship:				✓
Competence in being able to communicate in reading, writing and speaking the English language:				✓
Participation in Medical Staff Affairs				✓

Name of Applicant: Regan Theiler

How long have you known the applicant and in what capacity? 3 years / colleague

Question	Yes	No
To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner?	✓	
Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine?		✓
Do you know of any pending professional misconduct proceedings or medical malpractice claims?		✓
Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.)		✓
Do you know of any suspension, restriction, or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice?		✓
Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures?		✓
Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?		✓
Do you know of a failure to complete a residency training program(s)?		✓
Does the applicant call upon consults when needed?	✓	

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluation this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

- ✓ Close personal observation
- ___ General impression
- ___ A composite of faculty/staff evaluations
- ___ Other – Specify:

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend ~~Tristi Wood Muir, MD~~ Regan Nell Theiler, MD for licensure in Vermont.
Name of Physician

Signed: [signature] Date: 6-8-2011

Print or Type Name and Title: Tristi Wood Muir MD

Addendum 4A

Reference Form

Substitute forms are not acceptable. This form may be duplicated as needed.

This form is to be completed by the individual providing the reference.
Please return the completed form directly to the Board at:

Vermont Department of Health
Board of Medical Practice
108 Cherry Street, P.O. Box 70
Burlington, VT 05401

JUN 20 2011

Name of Applicant: Regan Theiler

The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. Thank you for your cooperation.

Please complete all parts of this form. If more room is needed, please attach additional information.

Dr. Regan Theiler was at UTMB

From 7/2007 to 6/2011. During that time, he/she was (List status in the Institution): Faculty, Ob/Gyn

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

	Poor	Fair	Average	Above Average
Basic medical knowledge:				✓
Professional judgment:				✓
Sense of responsibility:				✓
Moral character/ ethical conduct:				✓
Competence and skill:				✓
Cooperativeness, ability to work with others:				✓
History & physical exam taking:				✓
Record keeping:				✓
Case presentations:				✓
Patient management:				✓
Physician-Patient Relationship:				✓
Competence in being able to communicate in reading, writing and speaking the English language:				✓
Participation in Medical Staff Affairs				✓

Name of Applicant: Regan Theiler

How long have you known the applicant and in what capacity? Division Director

Question	Yes	No
To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner?	✓	
Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine?		✓
Do you know of any pending professional misconduct proceedings or medical malpractice claims?		✓
Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.)		✓
Do you know of any suspension, restriction, or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice?		✓
Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures?		✓
Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?		✓
Do you know of a failure to complete a residency training program(s)?		✓
Does the applicant call upon consults when needed?	✓	

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluation this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

- [x] Close personal observation
- [ ] General impression
- [ ] A composite of faculty/staff evaluations
- [ ] Other – Specify: ____

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend Regan Theiler for licensure in Vermont.
Name of Physician

Signed: [signature] MD Date: 6/13/11

Print or Type Name and Title: Russell Snyder MD
Director Division Gynecology
Dept OB/Gyn
Univ Tx Medical Branch @ Galveston

Addendum 4A

Reference Form

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Vermont Department of Health
Board of Medical Practice
108 Cherry Street, P.O. Box 70
Burlington, VT 05401

JUN 20 2011

Name of Applicant: Regan Theiler

The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. Thank you for your cooperation.

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From 7/2007 to 6/2011. During that time, he/she was (List status in the Institution): Faculty, Ob/Gyn

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

	Poor	Fair	Average	Above Average
Basic medical knowledge:				✓
Professional judgment:				✓
Sense of responsibility:				✓
Moral character/ ethical conduct:				✓
Competence and skill:				✓
Cooperativeness, ability to work with others:				✓
History & physical exam taking:				✓
Record keeping:				✓
Case presentations:				✓
Patient management:				✓
Physician-Patient Relationship:				✓
Competence in being able to communicate in reading, writing and speaking the English language:				✓
Participation in Medical Staff Affairs				✓

Addendum 4A, Continued

Name of Applicant: Regan Theiler

How long have you known the applicant and in what capacity? 4 years

Question	Yes	No
To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner?	✓	
Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine?		✓
Do you know of any pending professional misconduct proceedings or medical malpractice claims?		✓
Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.)		✓
Do you know of any suspension, restriction, or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice?		✓
Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures?		✓
Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere?		✓
Do you know of a failure to complete a residency training program(s)?		✓
Does the applicant call upon consults when needed?	✓	

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluation this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

- ✓ Close personal observation
- ___ General impression
- ___ A composite of faculty/staff evaluations
- ___ Other – Specify: ___

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend Regan Theiler for licensure in Vermont.
Name of Physician

Signed: [signature] Date: 16 June 11

Print or Type Name and Title: Professor & Chairman

GEORGIA COMPOSITE MEDICAL BOARD

EXECUTIVE DIRECTOR
LaSharn Hughes, MBA

BOARD CHAIRPERSON
Alexander S. Gross, MD

2 Peachtree St., N.W., 36th Floor • Atlanta, Georgia 30303 • Tel: 404.656.3913 • Fax 404.656.9723
http://www.medicalboard.georgia.gov E-Mail: Medbd@dch.ga.gov

JUN 20 2011

Wednesday, June 15, 2011

RE: **Regan Theiler, MD**

TO WHOM IT MAY CONCERN:

This is to certify that the above has been issued a license by the Georgia Composite Medical Board.

It is further certified that:

The license number is **305** and was issued on **July 2, 2004**

The current license status is **Lapsed**

The license expiration date is **June 30, 2007.**

Board Actions A review of public records indicates that no public board orders have been docketed.

Certified this day Wednesday, June 15, 2011.

Georgia Composite Medical Board

LaSharn Hughes
Executive Director

LLH/

1114

Licensure Verification Form
(Copy this form for multiple licenses)

Form #1

I am applying for a license to practice medicine. The Board requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the following Board: Vermont

TO BE COMPLETED BY APPLICANT

Applicant Name: Theiler (Last) Regan (First) Nell (Middle) ___ (Suffix)

Date of Birth: 10/26/73 Social Security Number: [redacted] License Number: 060305
(From State/Province you are sending this form to)

The applicant's social security number is to be used for purposes of identification and may not be used for any other reason.

I hereby authorize the licensing agency of the State/Province of Georgia to furnish the information to the Board indicated below.

Signature of Applicant [signature] Date 6/8/11

Board Name: Vermont Board of Medical Practice

Address: 108 Cherry St, P.O. Box 70 (Street) Burlington (City) VT (State/Province) 05401 (ZIP Code)

TO BE COMPLETED BY STATE LICENSING BOARD OR CANADIAN PROVINCE

Name of Licensee: ___ (Last) ___ (First) ___ (Middle) ___ (Suffix)

License Type: ___ License #: ___ Issue Date: ___ Expiration Date: ___

Is this license current? ☐ Yes ☐ No If No, please explain: ___

1) Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?
☐ Yes ☐ No ☐ Cannot answer under state law
If Yes, please explain: ___

2) Has the applicant ever been warned, censured, placed on probation, formal consent, reprimand or in any other manner disciplined; or has the applicant's license ever been revoked, suspended or, in any other manner, limited by a licensing or disciplinary authority in your state?
☐ Yes ☐ No ☐ Cannot answer under state law
If Yes, please explain: ___

Affix Board Seal Here

Board Authorized Signature: ___

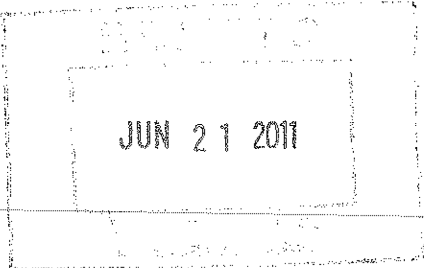
Title: ___

Date: ___

Please return this form to the Board listed at the top of this form.

Applicant Name: Regan Theiler Date: 6/8/11

RECEIVED
JUN 14 2011
BY- GCMB



Texas Medical Board

Mailing Address: P.O. Box 2018 • Austin, Tx 78768-2018
Phone (512) 305-7010

VERMONT BOARD OF MEDICAL PRACTICE LICENSING AND REGISTRATION
108 CHERRY ST.
BURLINGTON, VT 05402-0070

June 16, 2011

For: VERMONT BOARD OF MEDICAL PRACTICE LICENSING AND REGISTRATION

In response to a recent request, we verify the following information:
****

Physician: REGAN NELL THEILER, MD
License: M6911
Date Issued: 06/08/2007
Licensed by:
Date of Birth: 1973
Medical School: UNIV OF WISCONSIN MED SCH, MADISON
Graduation Year: 2003
Permit Expires: 02/28/2013

Registration Status:

This is to certify that the above-named physician is licensed to practice medicine in Texas.

Disciplinary Status:

The board has not filed any formal complaints or statements of charges against this physician.

Investigation Status:

Not applicable.

****

If you have any further questions, please contact the Hearings division

Sincerely,

Customer Information Center
BOARD SEAL

MED. AL STUDENT PERFORMANCE EVALL. ION

Regan N. Theiler

November 2002

IDENTIFYING INFORMATION

Regan Theiler is a fourth year student at the University of Wisconsin Medical School in Madison, Wisconsin.

UNIQUE CHARACTERISTICS

Regan is a student in the Medical Scientist Training Program at the UW Medical School. Her doctoral thesis was in the field of cytomegalovirus infection. She has two papers in press and one published in 2001. For additional details regarding the quality of her research, please refer to letters submitted by her thesis advisor.

ACADEMIC HISTORY

Date of Initial Matriculation in Medical School:	August 1996
Date of Expected Graduation from Medical School:	May 2003
Joint degree student:	
Date of Initial Matriculation in Other Degree Program:	August 1996
Date of Graduation from Other Degree Program:	December 2001
Type of Other Degree Program:	PhD, Microbiology
Was the student required to repeat or otherwise remediate any coursework during his/her medical education:	No
Was the student the recipient of any adverse action(s) by the medical school or its parent institution:	No

ACADEMIC PROGRESS

Basic Science and Introduction to Clinical Medicine Record

Regan did her basic science coursework from 1996 to 1998. Her first year GPA was a 3.51 and her second year GPA was 3.38. She received an A grade in histology, genetics physiology, neuroscience, renal, respiratory, GI, hepatic neoplastic diseases and psychiatry. Her USMLE Step 1 exam score was 239, which is in the 94th percentile nationally, and confirms her excellent preparation in the sciences basic to medicine.

During our Patient, Doctor and Society course that introduces students to clinical medicine, Regan received a satisfactory grade the first semester, a B the second and third semesters and an A the fourth semester. Her clinical instructors found her interview skills to be right on target for this stage in her career. They also noted that she does an excellent job of communicating her findings effectively in written format. Her physical exam skills as revealed by an OSCE were also right on target.

Required Clinical Clerkships and Clinical Elective Record

As a third year student, Regan achieved a 3.23 GPA. Her clinical attributes include outstanding problem-solving skills. She is able to critically analyze patient findings and integrate these with her strong knowledge of pathophysiology in order to construct an appropriate differential. She then logically works through the data to a diagnosis and treatment plan. Regan has a strong motivation and high standards that are apparent in her work ethic and passion for learning. She puts in long hours, reads constantly to expand her knowledge, is always prepared on the status of her patients, is very reliable and meticulous, and she is able to multitask because of her organizational and time-management skills. She is a quiet worker who goes about her business without needing to draw attention to her performance. Regan interacts with her patients and their

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UNIVERSITY OF WISCONSIN - MADISON TRANSCRIPT

Theiler, Regan Nell
DEGREES: BS 06/1996 DePaul University, Chicago, IL
PRELIM EXAMS PASSED 03/31/00 in Microbiology
PHD MINOR COMPLETED 05/15/98 Distributed
PHD MAJOR COMPLETED 05/18/00 Microbiology

OFFICIAL COPY
BIRTHDATE 10/26/73

MATRICULATION DATE 09/03/96

Course		CRS	GR	PTS
Fall 1996-97 MP5M P1 MED GRM-G Medical				
SESSION A1: SEP 03 - DEC 13				
ANATOMY 710	Histology and Organology	5.000	A	20.000
ANATOMY 711	Gross Human Anatomy	8.000	B	24.000
MED SC-M 800	Generalist Physician Partnrs	1.000	S	0.000
BMOLCHEM 704	Comprehensive Human Biochem	6.000	B	18.000
SUM:		20.000		
Spring 1996-97 MP5M P1 MED GRM-G Medical				
SESSION A1: JAN 21 - MAY 09				
MD GENET 721	Medical Genetics	2.000	A	8.000
MED SC-M 731	Neuroscience	7.000	A	28.000
MED SC-M 801	Clin Medicine & Practice I	3.000	B	9.000
PATH 703	General Pathology	2.000	B	6.000
PHYSIOL 720	Prin of Human Physiology	6.000	A	24.000
HIST MED 720	HIST PERSPECTIVES-MEDICINE	1.000	DR	
	COURSE DROPPED 02/20/97			
SUM:		20.000		
Summer 1996-97 MP5M P2 MED GRM-G Medical				
SESSION HD: JUN 16 - AUG 10				
BMOLCHEM 990	Adv Biomoleclr Chem & Rsrch	2.000	P	0.000
SUM:		2.000		
Fall 1997-98 MP5M P2 MED GRM-G Medical				
SESSION A1: SEP 02 - DEC 12				
M M & I 701	Infection and Immunity I	4.000	B	12.000
MED SC-M 703	Hematology	3.000	B	9.000
MED SC-M 715	Respiratory System	3.000	A	12.000
MED SC-M 719	Smr-Contemp Iss:Health Care	1.000	DR	
	COURSE DROPPED 09/03/97			
MED SC-M 802	Clin Medicine & Practice II	4.000	B	12.000
SUM:		14.000		
Spring 1997-98 MP5M P2 MED GRM-G Medical				
SESSION A1: JAN 20 - MAY 07				
MED SC-M 699	Directed Study	1.000	B	3.000
MED SC-M 702	Infection and Immunity II	4.000	B	12.000
MED SC-M 707	Gastrointestinal Tract	2.000	A	8.000
MED SC-M 708	Hepatic	2.000	A	8.000
MED SC-M 711	Male/Female Endocrine Sys	3.000	B	9.000
MED SC-M 716	Psychiatry	2.000	A	8.000
MED SC-M 718	Autopsy Pathology	1.000	S	0.000
MED SC-M 721	Neoplastic Diseases	2.000	A	8.000
MED SC-M 727	Pharmacology II	2.000	B	6.000
MED SC-M 804	Generalist Partners Prgm II	3.000	A	12.000
SUM:		22.000		

Course		CRS	GR	PTS
Fall 1998-99 MP5M P2 MED GRM-G Medical				
SESSION A1: SEP 02 - DEC 15				
M M & I 900	Journal Club	1.000	S	0.000
M M & I 901	Seminar	1.000	S	0.000
M M & I 990	Research and Thesis	1.000	A	4.000
MED SC-M 706	Cardiovascular System	3.000	B	9.000
MED SC-M 709	Renal	2.000	A	8.000
MED SC-M 717	Pharmacology	3.000	B	9.000
BMOLCHEM 914	Smr-Molecular Biosci (Adv)	1.000	S	0.000
SUM:		12.000		
Spring 1998-99 MP5M P3 MED GRM-G Medical				
SESSION A1: JAN 19 - MAY 06				
H ONCOL 721	Topic: Conduct of Science	1.000	S	0.000
M M & I 900	Journal Club	1.000	S	0.000
M M & I 901	Seminar	1.000	S	0.000
M M & I 914	Smr-Molecular Biosci (Adv)	1.000	S	0.000
M M & I 990	Research and Thesis	2.000	A	8.000
PATH 750	Cellulr & Moleclr Biol/Path	3.000	AB	10.500
BACT 568	MICROBIOL-ATOMIC RESOLUTIO	3.000	DR	
	COURSE DROPPED 03/02/99			
SUM:		9.000		
Summer 1998-99 MED P3 Med Prof Medical				
G677M GR Microbio-M Graduate				
SESSION DHH: JUN 14 - AUG 08				
M M & I 990	Research and Thesis	2.000	S	0.000
SUM:		2.000		
Fall 1999-2000 MED P3 Med Prof Medical				

PAGE 2 FOLLOWS

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UNIVERSITY OF WISCONSIN - MADISON TRANSCRIPT

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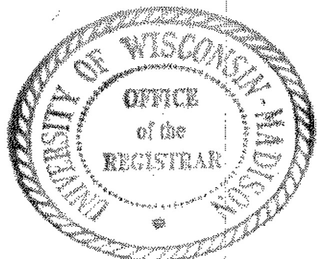
Theiler,Regan Nell

Subject	No.	Course	CRS	GR	PTS
		G677M GR Microbio-M Graduate			
		SESSION AMM: SEP 02 - NOV 28			
BIOCHEM	601	Protein&Enzyme Struct&Funct	2.000	B	6.000
		SESSION A1: SEP 02 - DEC 15			
BACT	640	Gen Virology-Multiplication	3.000	A	12.000
BACT	799	Practicum-Bact Teaching	1.000	A	4.000
M M & I	900	Journal Club	1.000	S	0.000
M M & I	914	Smr-Molecular Biosci (Adv)	1.000	S	0.000
M M & I	990	Research and Thesis	4.000	S	0.000
SUM:			12.000		
Spring 1999-2000		MED P3 Med Prof Medical			
		G677M GR Microbio-M Graduate			
		SESSION A1: JAN 24 - MAY 11			
BIOCHEM	603	Eukaryotic Molecular Biol	2.000	C	4.000
M M & I	900	Journal Club	1.000	S	0.000
M M & I	914	Smr-Molecular Biosci (Adv)	1.000	S	0.000
M M & I	990	Research and Thesis	5.000	S	0.000
AHABS	750	Vertebrate Viral Disease	3.000	AB	10.500
SUM:			12.000		
Summer 2000		G677M GR Microbio-M Graduate			
		SESSION DHH: JUN 12 - AUG 06			
M M & I	990	Research and Thesis	2.000	S	0.000
SUM: EARNED CR 2 GPA CR 0 GPA 0.000			2.000		0.000
Fall 2000-2001		G677M GR Microbio-M Graduate			
		MED P3 Med Prof Medical			
		SESSION A1: SEP 05 - DEC 15			
M M & I	720	Topics in Immunology	3.000	A	12.000
M M & I	901	Seminar	1.000	DR	
		COURSE DROPPED 09/17/00			
SUM: EARNED CR 3 GPA CR 3 GPA 4.000			3.000		12.000
Spring 2000-2001		G677M GR Microbio-M Graduate			
		MED P3 Med Prof Medical			
		SESSION A1: JAN 22 - MAY 10			
BACT	990	Research	2.000	S	0.000
ONCOLOGY	675	McArdle Student Seminar	1.000	S	0.000
SUM: EARNED CR 3 GPA CR 0 GPA 0.000			3.000		0.000
Summer 2001		G677M GR Microbio-M Graduate			
		SESSION DHH: JUN 18 - AUG 12			
BACT	990	Research	3.000	S	0.000
SUM: EARNED CR 3 GPA CR 0 GPA 0.000			3.000		0.000
Fall 2001-2002		MED P3 Med Prof Medical			
		G677M GR Microbio-M Graduate			
		SESSION A1: SEP 04 - DEC 14			
BACT	990	Research	3.000	S	0.000
		SESSION 062: OCT 29 - DEC 22			
SR MED	812	3rd Yr Primary Care Clrkshp	8.000	B	24.000
SUM:			11.000		

Doctor of Philosophy
Degree Conferred December 23, 2001
MAJOR: Microbiology
MINOR: Distributed

Subject	No.	Course	CRS	GR	PTS
Spring 2001-2002		MED P4 Med Prof Medical			
		SESSION 050: JAN 07 - FEB 17			
OBS&GYN	812	3rd Year Obs & Gynecology	6.000	A	24.000
		SESSION 051: FEB 18 - MAR 31			
PEDIAT	812	3rd Year Pediatrics	6.000	B	18.000
		SESSION 033: APR 01 - APR 21			
NEUROL	812	Third Year Neurology	3.000	B	9.[illegible]
		SESSION 004: APR 22 - APR 28			
OPHTHALM	812	Third Year Ophthalmology	1.000	AB	3.500
		SESSION 062: APR 29 - JUN 23			
MEDICINE	812	Prin Int Med-Basic Clrkship	8.000	B	24.000
		SESSION 025: JUN 24 - JUL 07			
ANESTHES	812	Third Year Anesthesia	2.000	B	6.000
SUM:			26.000		
Fall 2002-2003		MED P4 Med Prof Medical			
		SESSION 060: JUL 08 - SEP 01			
SURGERY	812	Third Year Surgery	8.000	B	24.000
		SESSION 042: SEP 03 - SEP 29			
PSYCHIAT	812	Third Year Psychiatry	4.000	A	16.000
		SESSION 043: SEP 30 - OCT 27			
OBS&GYN	925	High Risk Obst Clrk-Meriter	4.000	A	16.000
		SESSION 044: OCT 28 - NOV 24			
MEDICINE	971	Infect Disease Clerkshp-CSC	4.000	AB	14.000
		SESSION 045: NOV 25 - DEC 22			
OBS&GYN	910	Indep Rdg & Rsch-4th Yr Med	8.000	A	32.000
SUM:			28.000		

PAGE 3 FOLLOWS



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			CRS	GR	PTS
Spring 2002-2003 MED P4 Med Prof Medical					
		SESSION 040: JAN 06 - FEB 02			
SURGERY	923	Gen Surg Clrkshp-St Mary's	4.000	AB	14.000
		SESSION 041: FEB 03 - MAR 02			
MEDICINE	915	Therapeut&Cl Pharmacol-VAH	3.000	S	0.000
		SESSION 051: FEB 17 - MAR 30			
SR MED	856	Preceptorship-Eau Claire	6.000	AB	21.000
		SESSION 043: MAR 31 - APR 27			
MEDICINE	920	Req 4th Yr Med Subintrnshp	4.000	A	16.000
		SESSION 018: APR 28 - MAY 11			
MEDICINE	987	Crit Care/Med ICU-Marshfld	2.000	B	6.000
SUM:			19.000		

Doctor of Medicine
Degree Conferred May 18, 2003
MAJOR: Medicine

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GRADING SYSTEM

All credits are based on semester hours. A 4.000 grading system is used. Prior to 1951 [illegible] a 3.00 grading system was used. Intermediate grades of AB and BC were instituted as of September 1973.

Grades With Associated Grade Points Per Credit

	GRADE	GRADE POINTS
A	Excellent	4
AB	Intermediate Grade	3.5
B	Good	3
BC	Intermediate Grade	2.5
C	Fair	2
D	Poor	1
F	Failing	0
NR	No Report prior to 1999	0

Grades Which Do Not Have Associated Grade Points

CR	Credit	NW	No Work
DEF	Deferred	P	Progress
DR	Dropped	PE	Permanently Excused
[illegible]	Extended Incomplete	PI	Permanent Incomplete
[illegible]	Excused	Q	Question on credits
I	Incomplete	R	Registered
IF	Incomplete - Medical School Courses only	S	Satisfactory
IN	Incomplete in Credit/No Credit Course	U	Unsatisfactory
N	No Credit	W	Withdrew
NR	No Report beginning in 1999		

ABBREVIATIONS AND SYMBOLS

[illegible]	Failed course that has been repeated. Credits are not used to calculate cumulative GPA
#	Course taken Pass or [illegible] basis
*	Credits of Failing, CR, NR Repeat. Credits do not count toward degree
* With Honors	Full course in [illegible]
? On Credits	Question on credits
@	Repeat of a failed course
>	Course does not count toward degree
^	Credit/No Credit course in progress
ADV STG CRS	Credits [illegible] UW-Madison Campus
AU	Course taken for Audit credit
CRS	Number of credits
CUM	Cumulative totals
EARNED CRS	Total credits earned
GPA	Grade Point Average
[illegible] CR	Credits included in Grade Point Average calculation
[illegible]	Grade Required
H	Course taken for Honors credit
PTS	Grade Points
SUM	Semester Summer totals

YEAR LEVEL DEFINITIONS

1	= FRESHMAN - less than 24 credits and 48 grade points
2	= SOPHOMORE - 24 credits and 48 grade points
3	= JUNIOR - 54 credits and 108 grade points
4	= SENIOR - 86 credits and 172 grade points
5/GRR	= GRADUATE - A student pursuing a graduate degree
PF	= [illegible] & Year

COURSE NUMBERING SYSTEM

000 - 099	Special [illegible] Courses
100 - 299	Undergraduate Courses
300 - 699	Courses Open to [illegible] Or Graduates
700 - 999	Graduate And Professional Courses Including Seminars

A middle digit of 8 (i.e. 181) indicates an honors course. [illegible] are also shown by an H [illegible]

INCOMPLETES

The undergraduate [illegible] the grade of I [illegible] week of classes in the next semester [illegible] the student is in [illegible] students and most special students must remove the Incomplete by the end of the next [illegible] Incompletes that are not removed by the deadline [illegible] grade of F [illegible] removal of Incompletes may be extended with approval of the student's Dean's office. [illegible] students are not subject to the above Incomplete deadline. Students who are not in [illegible] period after an Incomplete is received may not remove the Incomplete without permission [illegible] Office. These Incompletes remain on the record as Permanent Incompletes [illegible]

LAW SCHOOL GRADES

The Law School has its own grading scale. [illegible] entering in 2004 and thereafter [illegible] of A+, A, A-, B+, B, B-, and so on through F.

Law students entering in 1992 [illegible] 2004, were [illegible] on a numerical scale [illegible] during that time period are as follows:

87-95	A	77-79	C
85-86	AB	70-76	D
83-84	B	65-69	F
80-82	BC		

From 1970 to 1992, the following grading system and [illegible]

87-100	A	70-76	D
82-86	B	0-69	F
77-81	C		

Detailed [illegible] concerning law grades is available from the University of [illegible] Office.

MEDICAL SCHOOL GRADES

Detailed information concerning [illegible] upon request of the student from the UW-Madison [illegible] Office. The [illegible] to medical students in Medical School Courses.

THE HONORS PROGRAM

Some Schools & Colleges have [illegible] awards based on grade point [illegible] These [illegible] of Honors courses are offered to students who have chosen to do [illegible] enriched manner in the subjects. The programs are entirely voluntary.

TRANSCRIPTS FROM OTHER INSTITUTIONS

The University of Wisconsin - Madison does not [illegible] of transcripts or other [illegible] institutions, including the University of Wisconsin - Extension.

RECORDING OF UW WORK PRIOR TO JANUARY 1972

Prior to January 1972 all [illegible] for work taken [illegible] of Wisconsin (UW-Madison, [illegible] UW-Green Bay, UW-Parkside, UW-Centers, and [illegible] one record and may appear on this transcript.

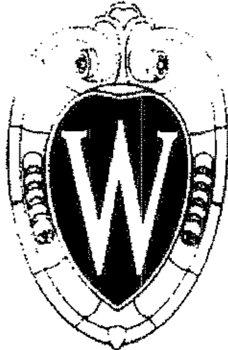
Transcripts
Office of the Registrar
University of Wisconsin - Madison
Madison, Wisconsin
608-262-3811
www.registrar.wisc.edu

This is [illegible]
[illegible]

ADDITIONAL TESTS: When [illegible] the words VOID VOID VOID [illegible] this paper is touched by fresh liquid bleach [illegible] released to a third party [illegible] of the student. This is [illegible] and Privacy Act of 1974. If you have any [illegible] ALTERATION OF THIS DOCUMENT MAY BE A CRIMINAL OFFENSE

[illegible]

UNIVERSITY OF WISCONSIN-MADISON



The Board of Regents of the University of Wisconsin System,
on the nomination of the faculty, has conferred upon

REGAN NELL THEILER

The Degree of

DOCTOR OF MEDICINE

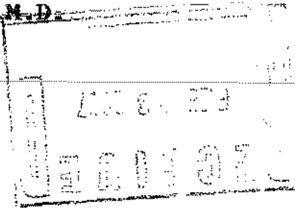
Together with all honors, rights, and privileges belonging to that degree.
In witness whereof, this diploma is granted.

Given at Madison in the State of Wisconsin
this eighteenth day of May in the year two thousand and three
and of the University the one hundred fifty-third.

Katharine Lyall	John D. Wiley	Guy A. Gottschalk
President, University of Wisconsin System	Chancellor, University of Wisconsin-Madison	President of the Board of Regents

SEAL
VERIFIED

I certify that this is a true and correct copy of the original diploma of Regan Nell Theiler, ~~M.D.~~

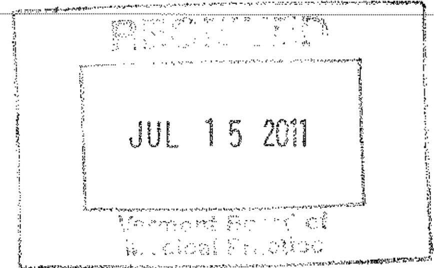


Sharon J. Greuel
Certification Officer

SEAL
VERIFIED

REGAN N. THEILER, MD, PHD, FACOG

CURRICULUM VITAE
July 11, 2011



PRESENT POSITION AND ADDRESS:

2007-Present Assistant Professor
Division of Gynecology
Department of Obstetrics and Gynecology
University of Texas Medical Branch
Galveston, Texas 77555-0587
409/370-9644
rntheile@utmb.edu

BIOGRAPHICAL:

Sex: Female
Date of Birth: October 26, 1973
Place of Birth: Osseo, Wisconsin
Citizenship: U.S.A.

EDUCATION:

2003-2007	Residency. Emory University, Atlanta Georgia Department of Obstetrics and Gynecology
1996-2003	M.D. University of Wisconsin-Madison Medical School, Madison, Wisconsin Medical Scientist Training Program
1998-2001	Ph.D. University of Wisconsin-Madison, Madison, Wisconsin Microbiology Doctoral Training Program
1992-1996	B.S. DePaul University, Chicago, Illinois Chemistry, with High Honor

PROFESSIONAL AND TEACHING EXPERIENCE:

2007-Present	Assistant Professor and Women's Reproductive Health Research (WRHR) Scholar Division of Gynecology, Department of Obstetrics and Gynecology, University of Texas Medical Branch, Galveston, Texas
2008-2011	Staff Physician, Planned Parenthood Gulf Coast, Houston, Texas
2006-2007	Administrative Chief Resident, Department of Gynecology and Obstetrics Emory University, Atlanta, Georgia
2005-2007	CDC Guest Researcher, Centers for Disease Control and Prevention

	Atlanta, Georgia
2003-2006	Resident, Department of Gynecology and Obstetrics Emory University, Atlanta, Georgia
1995	National Science Foundation Fellowship, Research Experience for Undergraduates University of Utah Medical Center and Department of Chemistry Bacterial Topoisomerases as Antimicrobial Targets

CERTIFICATION:

2009 Diplomate, American Board of Obstetrics and Gynecology
2010 Fellow, American Congress of Obstetricians and Gynecologists

LICENSURE:

Texas State Medical License – M6911

RESEARCH ACTIVITIES:

Interests include maternal/fetal infectious diseases, virology, and placental immunology.

2007-Present Women's Reproductive Health Research Scholar
National Institutes of Health K12 Mechanism
Principle Investigator: Gary D. V. Hankins, MD
Mentors: C. J. Peters, M.D. and Mahmoud Ahmed, PhD

2007-2011 National Institutes of Health Loan Repayment Program (LRP) for Clinical Researchers

2004-2005 Roche Diagnostics Grant: Cord Blood Screening for Cytomegalovirus Infection Using Quantitative PCR.

COMMITTEE ASSIGNMENTS:

2001-2003 Medical Scientist Training Program Admissions Committee, University of Wisconsin-Madison School of Medicine, Madison, Wisconsin

2005-2007 Residency Oversight Committee, Department of Gynecology and Obstetrics, Emory University School of Medicine, Atlanta, Georgia

2006-2007 Graduate Medical Education Resident Duty Hours Subcommittee, Emory University School of Medicine, Atlanta, Georgia

2006-2007 Graduate Medical Education Committee, Emory University School of Medicine, Atlanta, Georgia

2008-2009 Surgical Care Improvement Project Committee, John Sealy Hospital, University of Texas Medical Branch, Galveston, Texas

2008-Present Pharmacy and Therapeutics Committee, John Sealy Hospital, UTMB, Galveston, Texas

2009-Present Obstetrics and Gynecology Electronic Medical Records Committee.

2010-Present Obstetrics and Gynecology Education Committee

TEACHING RESPONSIBILITIES:

2009-Present Ob/Gyn Residents: Director of gynecology rotation for Ob/Gyn residents

2008-Present Small Group Facilitator – Ob/Gyn Clerkship – 3rd Year Students

2008-Present Practice of Medicine Course Facilitator and Lecturer

2009 Problem Based Learning Facilitator

MEMBERSHIP IN PROFESSIONAL AND SCIENTIFIC SOCIETIES:

2008-Present Society for Gynecologic Investigation

2009-Present Infectious Disease Society of America

1996-Present American Medical Association

2007-Present American Society for Microbiology

HONORS:

1992-1996 Arthur J. Schmitt Scholar, DePaul University, Chicago, Illinois

1993 CRC Freshman Chemist of the Year Award, Department of Chemistry, DePaul University, Chicago, Illinois

1993, 94, 96 Dean's Award for Academic Excellence, DePaul University, Chicago, Illinois

1994-1996 Claire Booth Luce Scholarship for Women in Math and Science, DePaul University, Chicago, Illinois

1996 Merck Index Award, Department of Chemistry, DePaul University, Chicago, Illinois

1998-2000 National Research Service Award, Molecular Biosciences Training Grant T32 GM 07215, University of Wisconsin-Madison Graduate School, Madison, Wisconsin

2001-2003 Wisconsin Distinguished Rath Graduate Fellow in Medicine, University of Wisconsin-Madison School of Medicine, Madison, Wisconsin

2005	Carlos Moisa Research Recognition Award, Department of Gynecology and Obstetrics, Emory University, Atlanta, Georgia
2006	Second Place – Resident Research Day, Department of Gynecology and Obstetrics, Emory University, Atlanta, Georgia
2007	Golden Apple Award, Emory University Medical Student Teaching Award, Emory University, Atlanta, Georgia
2008	Charles C. Shepard Science Award Finalist – Laboratory and Methods Manuscript "Breast Milk CD4+ T Cells Express High Levels of Chemokine Receptor 5 and CXC Chemokine Receptor 4 and are Preserved in HIV-Infected Mothers Receiving Highly Active Antiretroviral Therapy". (Journal of Infectious Diseases 2007; 195:965-972) June 2008
2010	McGanity Lectureship, Texas Association of Obstetrics and Gynecology Annual Meeting

OTHER AFFILIATIONS:

2008-Present	Member – UTMB Sealy Center for Vaccine Development
2009	Legislative Affairs Consultant to the University of Texas System
Ongoing	Peer reviewer (*ad hoc*) for: *Infectious Diseases in Obstetrics and Gynecology* *Journal of the American Medical Association (JAMA)* *The American Journal of Obstetrics and Gynecology* *The American Journal of Public Health* *The Journal of Clinical Virology* *The Journal of Travel Medicine*
2010-Present	Consultant to Bayer pharmaceuticals: Speakers bureau
2010-Present	Consultant to Merck pharmaceuticals: Implanon faculty trainer

MENTORSHIP:

Undergraduate Students:

1. Kyle O'Boyle. Summer undergraduate research program, 2008.

Medical Students:

1. Emiko Petrosky. Senior research elective, 2009-10.
2. Holly Dunn. Senior research elective, 2009-10.

Graduate Students:

1. Janet Appleton. PhD student 2009-10.
2. Reagan Street. Masters of Medical Science, 2010.

Residents:

1. Sara Mucowski, M.D. Resident research project, 2008-2011.
2. Paula Doyle, M.D. Resident research project, 2008-2010.
3. Katie Gillaspy, M.D. Resident research project, 2008-2010.
4. Teresa Walsh, M.D. Resident research project, 2010-ongoing.
5. Katheryn Williams, M.D. Resident research project, 2010-ongoing.
6. Johanna Voutyras, M.D. Resident research project, 2011-ongoing.

Advisory Committee Memberships:

1. Nguyen V. Nguyen, medical student honors thesis
2. Dara Havemann, M.D. Masters of Medical Science

BIBLIOGRAPHY:

ARTICLES IN PEER-REVIEWED JOURNALS

1. **Theiler, R.N.** and Compton, T.: Characterization of the Signal Peptide Processing and Membrane Association of Human Cytomegalovirus Glycoprotein O, *Journal of Biological Chemistry*, 2001; 276:39226-39231. PMID: 11504733. Impact factor: 5.32.

2. Kinzler, E*., **Theiler, R.N*.** and Compton, T.: Expression and Reconstitution of the gH/gL/gO Complex of Human Cytomegalovirus, *Journal of Clinical Virology*, 2002; Supplement 2: S87-S94. PMID: 12361760. Impact factor: 3.12. *These authors contributed equally.

3. **Theiler, R.N.** and Compton, T.: Distinct Glycoprotein O Complexes Arise In a Post-Golgi Compartment of Cytomegalovirus-Infected Cells, *Journal of Virology*, 2002; 76:2890-2898. PMCID135985. Impact factor: 5.15.

4. Salani, R., **Theiler, R.N.**, and Lindsay, M.: Uterine Torsion and Fetal Bradycardia Associated with External Cephalic Version, *Obstetrics and Gynecology*, 2006; 108:820-22. PMID: 17018516. Impact factor: 4.35.

5. Jamieson, D.J., **Theiler, R.N.**, and Rasmussen, S.A.: Emerging Infections and Pregnancy, *Emerging Infectious Diseases*, 2006; 12:1657-62. PMID: 17283611. Impact factor: 6.79.

6. **Theiler, R.N.**, Caliendo, A., Pargman, S., Berga, S., Raynor, B.D., and Jamieson, D.J.: Umbilical Cord Blood Screening for Cytomegalovirus DNA by Quantitative PCR, *Journal of Clinical Virology*, 2006; 37:313-16. PMID: 17035082. Impact factor: 3.12.

7. Kourtis, A.P., Ibegbu, C., **Theiler, R.N.**, Xu, Y., Bansil, P., Jamieson, D.J., Lindsay, M., Butera, S., Duerr, A.: Breast milk CD4+ T cells express high levels of C chemokine receptor 5 and CXC chemokine receptor 4 and are preserved in HIV-infected mothers receiving highly active antiretroviral therapy, *Journal of Infectious Disease*, 2007; 195:965-72. PMID: 17330786. Impact factor: 5.86.

8. **Theiler, R. N.** Evidence-based antimicrobial therapy in pregnancy: long overdue. *Clinical Pharmacology and Therapeutics*, 2009; 86:237-38. PMID: 19707213. Impact factor: 6.96.

9. **Theiler, R. N.**, Farr, S.L., Karon, J.M., Paramsothy, P., Viscidi, R., Duerr, A., Cu-Uvin, S., Sobel, J., Shah, K., Klein, R.S., and Jamieson, D.J. High risk HPV reactivation in HIV-infected

women: risk factors for cervical viral shedding. Obstetrics and Gynecology, 2010;115: 1150-58. Impact factor: 4.36.

10. Street, R.M., Mucowski, S.J., Gillaspy, K. R., Snyder, R.R., and **Theiler, R.N.** Dystroglycan expression in human placenta: basement membrane localization and subunit distribution change between the first and third trimester. *Accepte for publication: Reproductive Sciences.*

INVITED PUBLICATIONS

1. **Theiler, R.N.**, Rasmussen, S.A., Treadwell, T., and Jamieson, D.J.: Emerging and Zoonotic Infections in Women. *Infectious Disease Clinics of North America*, 2008; 22:755-772.

2. Ward, K., and **Theiler, R.N.**: Once-Daily Dosing of Gentamicin in Obstetrics and Gynecology. *Clinical Obstetrics and Gynecology*, 2008; 51(3):498-506.

3. Fox, K., and **Theiler, R.N.** Vaccination in Pregnancy. *Current Pharmaceutical Biotechnology*, 2011; 12: 789-796.

ABSTRACTS

1. Regan N. Theiler and Teresa Compton, Characterization of the Membrane Orientation of Human Cytomegalovirus Glycoprotein O. Oral Presentation at Wisconsin-Purdue Virology Conference (WISPUR), Argonne National Laboratory, Chicago, Illinois, 1999.

2. **Regan N. Theiler** and Teresa Compton, Characterization of the Membrane Association of Human Cytomegalovirus Glycoprotein O, A Component of the Viral Fusion Machinery. Keystone Symposium on Cell Biology of Virus Entry, Replication, and Pathogenesis, Taos, New Mexico, 2000.

3. **Regan N. Theiler,** Eric R. Kinzler, and Teresa Compton, Characterization and Reconstitution Of the Tripartite Envelope Complex, gH/gL/gO, of HCMV. Oral Presentation at 8th International Cytomegalovirus Conference, Monterrey, California, 2001.

4. **Regan N. Theiler** and Teresa Compton, Characterization of a Tripartite Fusion Glycoprotein Complex of Human Cytomegalovirus. Oral Presentation at the American Society for Virology, 20th Annual Meeting, Madison, Wisconsin, 2001.

5. **Regan N. Theiler,** A. Caliendo, S. Pargman, M. McPheeters, S. Berga, B.D. Raynor and D.J. Jamieson, Umbilical Cord Blood Screening for Cytomegalovirus DNA by Quantitative PCR. Oral Presentation at International Infectious Disease Society for Obstetrics and Gynecology USA (I-IDSOG) Meeting, Alexandria, Virginia, 2006.

6. **Regan N. Theiler** and C.J. Peters, Lymphocytic Choriomeningitis (LCMV) Model of Congenital Viral Infection and Immunity. Women's Reproductive Health Research Meeting, Rochester, New York, 2008.

7. Janet Appleton and **Regan N. Theiler**. Characterization of Lymphocytic Choriomeningitis Virus Infection of Human Placenta. Society for Gynecologic Investigation (SGI) 57th Annual Meeting, Orlando, Florida, 2010.

8. Sara J. Mucowski, Reagan M. Street, and **Regan N. Theiler**. The Role of α-Dystroglycan in Placentation. Society for Gynecologic Investigation (SGI) 57th Annual Meeting, Orlando, Florida, 2010.

9. **Regan N. Theiler**, Shaleen Theiler, and C.J. Peters. Viral Replication and Immune Response Differ after Infection of First vs. Third Trimester Human Placenta. Society for Gynecologic Investigation (SGI) 58th Annual Meeting, Miami Beach, Florida, 2011.

10. Reagan Street and **Regan N. Theiler.** Dystroglycan Expression in Gynecologic Cancers. Society for Gynecologic Investigation (SGI) 58th Annual Meeting, Miami Beach, Florida, 2011.