Application - Physician

Name	Donna Burkett
Credential	Physician

Fee Details

Application	$625.00
	$625.00

Introduction

Vermont Department of Health - Board of Medical Practice
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
medicalboard@vdh.state.vt.us
802-657-4220 or 800-745-7371

Dear Doctor:

The Board of Medical Practice is pleased that you have chosen to apply for licensure in Vermont.

Uniform Application for Physician Licensure (UA):
The Board has adopted the Uniform Application for Physician Licensure (UA) into its Medical Licensing Application. This application will make it easier for physicians to apply for licensure in states that utilize this application (UA). The Vermont Board of Medical Practice is one of the first boards to incorporate the UA into its state license application.
Please utilize the Instructions & Helpful Hints to complete the application. It is recommended that you review the Board's rules to ensure that you meet the eligibility requirements on our website at **http://www.healthvermont.gov/hc/med_board/bmp.aspx**. The following factors may negatively impact the application process: illegibility, incomplete or inaccurate information, failure to enclose the required fee, and failure to arrange for the required direct source verifications. Failure to answer all questions completely or accurately, or the omission or falsification of materials or facts may be cause for denial of your application, disciplinary action after licensure, or delay your license from being issued. If you have questions about the application or forms, please contact this office before you submit the application.

The Federation Credentials Verification Service (FCVS):
The Board accepts the use of FCVS to primary source verify core physician credentials as part of the licensure process. If using FCVS, the Federation of State Medical Boards (FSMB) credential verification service, the Board recommends completing the FCVS application first or simultaneously with the Vermont Board of Medical Practice Application for License.

FCVS is a service of the (FSMB) and was created to help license portability for physicians. FSMB is a national not-for-profit organization that provides this service for state medical licensing authorities in the United States, Guam, Puerto Rico and the Vigrin Islands, (contact FCVS for a complete state listing of requiring and accepting licensing authorities).

By using FCVS to verify your credentials, you will establish a permanent repository of primary source-verified documents. Once your file is established, these documents will be available for your use at any time. The documents that FCVS verifies and stores for you fall into the following categories:

- Identity
- Medical Education
- Postgraduate Training
- Examination History (state licensing authorities only)
- Board Action/Disciplinary History
- ECFMG Certification (if applicable)
- ABMS Board Certification

You pay FCVS a fee for gathering and forwarding your initial or Subsequent Profile, and can also forward additional Profiles to other licensing boards and health care entities of your choice. Average processing time to collect and forward your initial Profile is approximately 8-12 weeks. Once your permanent file is established, updated Subsequent Profiles are typically forwarded within 2-3 weeks. Most physicians will benefit greatly throughout their career by having their credentials permanently stored and easily accessible.

Contact FCVS at 888-ASK-FCVS (or outside the U.S. at 1-817-868-5000) for additional information regarding the service and its fees. If your credentials are already on file with FCVS directly at the above number to have them forwarded to the Vermont Board of Medical Practice.

Sincerely,
Vermont Board of Medical Practice

Instructions for completing the Application for Licensure to Practice Medicine in Vermont

Application Fees: $625, this fee is non-refundable.

Examination Transcript. Request that a transcript of your exam scores be sent directly to the Vermont Department of Health - Board of Medical Practice from the appropriate examining agency. **If you are using FCVS, they will obtain your exam score transcripts based on the information you provide in the FCVS application.** For those that have taken any component of the NBME in conjunction with another exam (USMLE/FLEX), you must request the transcripts from the NBME.

- USMLE/FLEX/SPEX - Request transcripts online at **www.fsmb.org** or call (817)868-4000.
- NBME - Download the request form at **www.nbme.org/Cert-tran/certification.html** or call (215)590-9500.
- State Exam - Contact the state licensing board in which you took the exam.
- LMCC - Call (613)521-6012

ECFMG (if applicable): Request that a Confirmation Report of ECFMG Certification be sent directly to the Vermont Department of Health - Board of Medical Practice from the ECFMG. **If you are using FCVS, you do not need to contact the ECFMG. You will complete the ECFMG release forms included in the FCVS application and FCVS will coordinate with the ECFMG to obtain your certification.**

- ECFMG - Download the request form at **www.ecfmg.org/cvs/state-medical-boards.html** or call (215)386-5900

American Medical Association Profile. Request an American Medical Association Profile. You will need to complete the AMA Physician Profile Service Order Form. This form must be sent by the applicant directly to the AMA. Download the requests forms at:

- Physician Profile Service Form: **https://profiles.ama-assn.org/amaprofiles/info/pdf/profileorderform.pdf**
- AMA - Call at (800)665-2882

National Practitioner Data Bank Self Query. Effective September 1, 1990, the Federal government opened the National Practitioner Data Bank. This data bank, mandated by Congress, tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments. **You must self query this data bank on your own as part of the applicaiton process for a Vermont medical license.** Simply query the data bank using the instructions below and when you receive the response, **SEND THE ORIGINAL, UNALTERED** response to the Board. You may keep a photocopy if you wish.

- Log-on to web site for NPDB: **www.npdb-hipdb.hrsa.gov/**
- Select "Report to and Query the Data Banks"
- Click on "Perform a Self-Query"
- Select the type of self-query you wish to perform, "Individual or Organization"
- Provide ALL required information and credit card information (Checks and Cash are not accepted)
- Once all information is complete, click CONTINUE. A formatted copy of the self-query is generated immediately with a Data Bank Control Number (DCN) listed at the top of the page. Print this formatted copy, and keep the DCN to monitor the processing status of your self-query. To print a query from the IQRS, you must have Adobe Acrobat Reader version 4.0 or higher installed on your computer.
- To complete the self-query process, you must sign the formatted self-query application in the presence of a notary public and mail it to the NPDB-HIPDB. Self-queries received without notarization or with an incomplete notarization are rejected. Notarized forms that are missing credit card information will be rejected.

Application Instructions. Complete the application as instructed in each section. Please see below for additional instructions and documents that need to be submitted to the Board.
Additional Instructions - Please see below additional instructions for completing specific sections of the Uniform Application (UA).

- Malpractice Claims - You will complete malpractice claims information in Addendum 2.
- Application for Physician Licensure Instructions Checklist (UA Checklist) - The checklist states that you must submit a certified birth certificate or a current, valid passport. **You must submit a certified (NOT NOTARIZED) Birth Certificate, the Board will not accept a current, valid passport.**

Additional Documents - submit the following documents to the Board along with the completed application (if applicable):

- Certified Copy of Birth Certificate. **If you are using FCVS, you do not need to submit this document to the Board. This will be collected by FCVS as part of your FCVS Physician Profile. **A passport is NOT Acceptable****
- Copy of American Specialty Board Certificate(s).
- Curriculum vitae (CV/Resume).

- Addendum 4A - This form must be completed by the individual providing the reference. Make three (3) copies of this Reference Form and mail a copy to each individual that you have listed as a reference. The completed reference form must be returned directly to the Board.
- To complete the application you must download the forms located **here** and send them to the Board.

Name & Address

Name:

Indicate your full legal name (use no initials). 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. Last Name:
   Burkett
2. First Name:
   Donna
3. Middle Name:
   Lynn
4. Suffix:
5. M.D. or D.O.?
   M.D.
6. All other names used:

Previous Name	From Month	From Year	To Month	To Year	Reason for Change

7. 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.

Address/Phone:

Please complete all sections. 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.

8. Enter your MAILING ADDRESS information:

Attention

Street

City **State** **Zip** **Country** United States

E-mail Address

Telephone **Alternate Phone (e.g. Pager)**

9. Enter your PUBLIC ACCESS address information:

Attention Stacy Bradley

Street 128 Lakeside Avenue, Suite 301

City Burlington **State** VT **Zip** 05401

Country United States

Telephone

E-mail Address

Alternate Phone (e.g. Pager)

Identification

If you have not provided one to FCVS you must submit a certified birth certificate. Notarized copies and passports are not accepted.

10. Date of Birth:

11. Birth City:
Hattiesburg

12. Birth State/Province:
Mississippi

13. Birth Country:
United States

14. Gender:
Female

15. Social Security Number:

The disclosure of your social security number is manditory, 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.

16. NPI Number:
1760445506

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

17. Are you a U.S. Citizen?
Yes

Medical School

To ensure the eligibility of your school, please refer to the California Medical Board approved school list (available here.)

18. Medical Schools:
List all medical schools you have attended, even those from which you did not graduate, in chronological order. If you are not using FCVS, you must complete the "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 forward all documentation directly to this Board.

School	Graduation Date
School Name: University of North Carolina **State**: North Carolina **Country**: United States **School Type**: Medical School **Degree**: MD	05/30/1995

19. Fifth Pathway (if applicable):
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.

School	Graduation Date

Postgraduate Training

Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. If you are not using FCVS, you must complete the "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have

attended. You must upload 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.

20. Postgraduate Training (do not use abbreviations):

Site Name	End Date	Specialty
Oregon Health Sciences University	06/30/1998	Family Practice

Examination History

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.

21. List each licensure examination, U.S. or international, you have taken.

Examination	State	Most Recent Date Taken	Pass?	Score	Number of Attempts
USMLE Step 1	North Carolina	06/08/1993	Yes		1
USMLE Step 2, CK	North Carolina	03/01/1995	Yes		1
USMLE Step 3	Oregon	05/14/1996	Yes		1

ECFMG

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****.*

ECFMG (if applicable):

22. Certificate Number:

23. Issue Date:

24. Valid Through Date:

State/Province Professional Licensure

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 "Licensure Verification" for (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.*

25. State Licensure

State	Profession	License Number	Issue Date	Expiration Date	Status
Oregon	MD	MD20096	10/18/1996	01/01/2002	Surrendered
North Carolina	MD	200100124	02/01/2001	01/10/2014	Active
Virginia	MD	0101241288	02/01/2007	01/31/2014	Active
West Virginia	MD	22710	05/01/2007	06/30/2014	Active
South Carolina	MD	29999	09/01/2007	06/30/2015	Active

Chronology of Activities

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 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 APPLICATION.** Be sure to indicate the percentage of working time spent in clinical administrative duties.

26. Chronology of Activities

Practice/Employment Name	Street Address	City	State	Zip Code	Position and Department	Experience Type	Start Date	End Date	% Clinical / % Administrative
Oregon Health Sciences University	3181 SW Sam Jackson Park Rd	Portland	Oregon	97239	Resident	Residency	07/01/1995	06/30/1998	
travel between jobs	3 E A				acation	Other	07/01/1998	08/30/1998	
Providence Health Systems	North Portland	Portland	Oregon	97217	Physician	Employment	08/30/1998	12/31/1999	
family and medical leave/seeking employment/moving					amily leave	Other	01/01/2000	04/01/2001	
WNC OB-Gyn and Family Practice	16 McDowell St	Asheville	North Carolina	28801	Physician	Employment	04/01/2001	02/14/2005	
Seeking employment					looking for part-time work and being parent	Other	02/15/2005	06/30/2005	
MAHEC	118 WT Weaver Blvd	Asheville	North Carolina	28804	Faculty physician, part-time	Employment	07/01/2005	05/17/2013	
Planned Parenthood Health Systems, Inc	603 Biltmore Ave	Asheville	North Carolina	28801	Affiliate Medical Director, Medical Services	Employment	07/15/2006		

Medical Malpractice Claims Information

27. **Malpractice Liability Claims Information**
Have you ever been involved in a Malpractice Liability Claim? If you have you must provide complete and thorough information in the respective section of Addendum 2.
No

Affidavit & Authorization for Release of Information

Affidavit and Authorization for Release of Information:

To complete this application you must download the **Affidavit and Authorization for Release of Information** form and attach a recent (less than 6 months old) passport quality, color photograph of yourself. 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 the Board.

Addendum 1

28. Were you in active clinical practice in the past 12 months?
Yes

29. **Years of Practice**
What year did you start practicing as a medical professional?
1995

30. Have you ever held a Vermont Limited Temporary License?
No

31. If yes, License Number:

32. Premedical Education

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

School	Graduation Date

33. Specialty Board Certifications

Specialty	Certification Board	Certification Date	Specialty Expiration Date
Family Practice	American Board of Family Medicine	07/01/1998	06/30/2014

34. Practice
Do you have hospital privileges?
No

35. List all hospitals where you have, or previously have had, staff privileges.

Facility Name	State	Start Date
Providence Health Systems	Oregon	08/30/1998
Mission Hospital	North Carolina	10/01/2001

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.

It is very important for us to receive 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.

If you have been convicted of an alcohol or drug related crime, you must contact the Vermont Practitioners Health Program to arrange for a confidential evaluation (802-223-0400). The evaluation will need to be received by this Board prior to licensure.

36. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] Have you been convicted of any crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets)? For purposes of this question, "convicted" means that you pleaded guilty or that you were found adjudged guilty by a court of competent jurisdiction.
No

37. **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 adjudged guilty by a court of competent jurisdiction. **Please provide copies of papers fully documenting the convictions.**

Date of Conviction	Court of Conviction	City	State	Description

38. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]
Have there been any 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?
No

39. 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 continue without finding by a court of competent jurisdiction.

Date of Charges	Court	City	State	Description of Charges

40. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)]
Have there been any formal charges served, findings, conclusions, and/or orders of the Board of Medical Practice (including stipluations), and/or final disposition of such matters by the courts, if appealed?
No

41. 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 stipluations), and final disposition of such matters by the courts, if appealed.

Date	Final Disposition Summary

42. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]
Have there been any formal charges served against you by licensing or certification authorities of other states?
No

43. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]
Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states. **Please provide copies of papers fully documenting these matters.**

Date of Disposition	Licensing Authority	City	State	Description of Disposition

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

44. Have your hospital privileges ever been revoked or involuntary restricted in relation to competence or character?
No

45.
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 upload copies of papers fully documenting these matters.

Date of Restriction	Hospital Name	State	Nature of Restriction	Reason for Restriction

46. Have your hospital privileges ever been restricted, or have you ever resigned or not renewed your medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital?
No

47.
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 upload copies of papers fully documenting these matters.

Date	Hospital Name	State	Action	Nature of Action	In Lieu or In Settlement

Appointments/Teaching [See 26 VSA § 1368(a)(12)]
Note: answering the Appointments and Teaching questions 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.)

48.
A. Appointments
Please provide information about your appointments to medical school or professional school facilities.

School	City	State	Nature of Position	Date Started	Date Ended
MAHEC (UNC School of Medicine)	Asheville	North Carolina	Associate Faculty	07/01/2005	05/17/2013

49.
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	Date Started	Date Ended
MAHEC	Asheville	North Carolina	Associate Faculty - obstetrics, outpatient care, vasectomy, reproductive health	07/01/2005	05/17/2013

50. Publications [See 26 VSA § 1368(a)(13)]
Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web.
Please provide information regarding your publication in peer-reviewed medical literature within the past 10 years.

Title	Publication	Publication Date

51. Activities [See 26 VSA § 1368(a)(14)]
Note: Answering this question 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 activites and awards.

Activity or Award

52. When are you scheduled to begin work in Vermont?
September 9, 2013

53. Provide the following information for each practice location. Be sure to indicate which is to be your primary practice location.

Practice Name	City	State	Primary Practice	Languages	Accepts Medicaid?	Accepts New Medicaid Patients?
Planned Parenthood of Northern New England -Burlington Health Center	Burlington	Vermont	Yes	Spanish	Yes	Yes
Planned Parenthood Northern New England - Barre Health Center	Barre	Vermont	No		Yes	Yes
PPNNE -Bennington Health Center	Bennington	Vermont	No		Yes	Yes
PPNNE - Brattleboro	Brattleboro	Vermont	No		No	No
PPNNE - Hyde Park	Hyde Park	Vermont	No		Yes	Yes
PPNNE - Middlebury	Middlebury	Vermont	No		Yes	Yes
PPNNE - St. Albans	St. Albans	Vermont	No		Yes	Yes
PPNNE - St. Johnsbury	St. Johnsbury	Vermont	No		Yes	Yes
PPNNE - Williston	Williston	Vermont	No		Yes	Yes
PPNNE - Claremont	Claremont	New Hampshire	No		Yes	Yes
PPNNE - Keene	Keene	New Hampshire	No		Yes	Yes
PPNNE -Derry	Derry	New Hampshire	No		Yes	Yes
PPNNE - Exeter	Exeter	New Hampshire	No		Yes	Yes
PPNNE - Rutland	Rutland	Vermont	No		Yes	Yes
PPNNE - Newport	Newport	Vermont	No		Yes	Yes
PPNNE - Manchester	Manchester	New Hampshire	No	Spanish	Yes	Yes
PPNNE - West Lebanon	West Lebanon	New Hampshire	No		Yes	Yes
PPNNE - Biddeford	Biddeford	Maine	No		Yes	Yes
PPNNE - Portland Health Center	Portland	Maine	No		Yes	Yes
PPNNE - Sanford	Sanford	Maine	No		Yes	Yes
PPNNE - Topsham	Topsham	Maine	No		Yes	Yes

54. Provide a brief description of your anticipated practice:
I will be the medical director of Planned Parenthood of Northern New England, so my clinical duties will be limited to 1-2 days per week, and will vary with the needs of the organization. I will provide the broad range of reproductive health care and a limited range of family practice.

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

City	State	From	To
Asheville	North Carolina	09/13/2000	08/09/2013

Addendum 2

56. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?
No

57. State:

58. Year:

59. Circumstances under which you applied and were denied a certificate to practice medicine or any other healing art:

60. Denied certificate to practice medicine or any other healing art - Upload documents

61. Have you ever withdrawn an application for a license or certificate to practice medicine or any other healing art?
No

62. State:

63. Year:

64. Circumstances under which license or certificate was withdrawn, denied, revoked, not renewed, or otherwise terminated:

65. Withdrawal or denial of license or certificate - Upload documents:

66. Have you ever voluntarily surrendered or resigned a license or certificate to practice medicine or any other healing art in lieu of disciplinary action or any other reason?
No

67. State:

68. Year:

69. Circumstances:

70. Voluntary surrendered or resigned a license or certificate to practice medicine or any healing art - Upload documents:

71. 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)?
No

72. Name of organization involved:

73. Date:

74. Duration:

75. Action Taken (add all that apply):

76. Circumstances:

77. Disciplinary charges or actions - Upload documents:

78. Have you ever been denied the privilege of taking an examination before any state medical examining board?
No

79. State:

80. Circumstances under which examination privileges denied:

81. Denial of examination privileges - Upload documents:

82. Have you ever discontinued your education, training, or clinical practice for a period of more than three (3) months NOT including premedical education?
Yes

83. If yes, please explain and include the dates over which your education, training, or clinical practice was discontinued:
These are included on my chronology, and include 2 leaves that I took for childbearing, childrearing and for family reasons. I have no documents to support this.

84. Discontinued Education, Training, or Clinical Practice - Upload documents:

85. Have you ever been dismissed or suspended from, or asked to leave a training program before completion?
No

86. Residency Training Program(s)

87. Location of Program(s)

88. Year:

89. Circumstances:

90. 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?
No

91. Institution involved:

92. Location:

93. Year:

94. Circumstances:

95. Affecting health care institution staff privileges, employment or appointment - Upload documents:

96. 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?
No

97. Name of organization involved:

98. Type of restriction:

99. Date:

100. Circumstances:

101. Privilege to prescribe controlled substances - Upload documents:

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

No

103. Court:

104. City and state:

105. Charge:

106. Description:

107. Status:

108. Date:

109. Defendant in criminal proceeding - Upload Documents:

110. Do you currently, or have you ever, prescribed any prescription medication over the internet? This does not include any prescribing you would do using electronic medical records in your practice.
No

111. Please provide a general description of your practice of internet prescribing:

112. **Medical Malpractice Court Judgments/Settlements** **[See 26 VSA § 1368(a)(6A)]** Have you ever been involved in a Malpractice Liability Claim? 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.
No

113.
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.

Date of Judgment

114.
B. Settlements Please provide a description of all settlements 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 Of Settlement

Medical Malpractice Claim
For each response provided in the previous Medical Malpractice Judgements and/or Settlements questions you must complete the form located here. Please download the form, complete it for each response, and then upload to each respective response. **This information is required for each and every response provided for Judgements and/or Settlements.**

115. **Important: In addition to the above information, please upload 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.**

Addendum 3

Addendum 3

This information is confidential and is exempt from public disclosure.

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

117. Court:

118. City and state:

119. Charge:

120. Description:

121. Status:

122. Date:

123. **Criminal Investigation - proceeding - Upload documents**

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

125. Licensing or certification board:

126. Date:

127. Location of Licensing Board:

128. Circumstances:

129. **Investigation by other licensing or certification board - proceeding - Upload documents**

MEDICAL QUESTIONS

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

DEFINITIONS

In answering the following questions, please use these definitions:

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make 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 and 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 podiatrist.

"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.

130. 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?

131. In explaining "Yes" answer to the previous question, 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.

132. Please upload any documents you have that are relevant to this matter.

133. 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?

134. In explaining a "Yes" answer to the previous question, 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.

135. Please upload any documents you have that are relevant to this matter.

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

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

138. Please upload any documents you have that are relevant to this matter.

Medical condition, treatment, use of chemical or illegal substances:

139. Treating organization:

140. Address:

141. Telephone:

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

143. Dates of illness or dependency (from, to):

144. Dates of treatment (from, to):

145. Name of rehabilitation/professional assistance or monitoring program:

146. Address:

147. Telephone:

148. Contact person at Program:

Addendum 4

149.

Addendum 4

List of Three (3) References

List a total of three (3) references in the section below. The individuals listed must be a fully licensed physician/podiatrist attesting to your character and professional abilities.

Chief of Service/Staff must be used as one of your references

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

****NOTE: If you are unable to provide references from these individuals because you have never held hospital privileges, provide such an explanation below. Three other references from physicians/podiatrists you have worked with most recently will then be required.***

****NOTE: A separate reference form must be completed by each individual providing the reference. The individual providing the reference should return the form directly to the Board.***

Reference First Name	Reference Last Name	Address Line 1	Address Line 2	City	State	Zip Code	Phone Number	Email Address	Years Known	Organization/Capacity of Relationship
Alan	Johnson	257 McDowell St.		Asheville	North Carolina	28803				Mission Hospital Chief of Staff
Steve	Hulkower	118 WT Weaver Blvd		Asheville	North Carolina	28804			20	MAHEC Chair of Family Medicine/ most recently as supervisor
Lisa	Ray	118 WT Weaver Blvd		Asheville	North Carolina	28804			18	MAHEC Family Health/ colleague

150. Provide an explanation as to having never held hospital privileges:

Addendum 5

Vertmont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer these questions.

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)

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

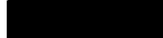
Regarding Taxes

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 taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

152. You must select one of the two statements below regarding taxes:
I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000.00 fine or both.)

The disclosure of your social security number is manditory, 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.

153. Social Security Number:

154. Date of Birth:


155. 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.
Yes

156. Date:
07/02/2013

Addendum 6

157.

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 either:

A. This does not apply to me because I don't have any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense, or

B. 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.

Yes

158. Date:
07/02/2013

Application Payment

159. You must choose one of the following payment options to complete your application. Note: Your application will NOT be processed by the Medical Board until payment is received. If you are a commissioned officer on active duty in the armed forces, you must submit a copy of your current active duty orders.
Self / Credit Card

Review

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

This form should be sent to the state board you are applying to, NOT to FSMB. JUL 9 2013

Applicant:

Securely tape or glue a recent (less than 6 month old) front-view 2" x 2" passport-type color photo of yourself in the square below.

Sign this form with attached photo in the presence of a notary public.

Send the notarized form to the board you are applying to for licensure.

DO NOT SEND THIS FORM TO FSMB.

Doing so will cause a delay with your state board application.

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 Uniform Application for Physician State 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.

Donna L Burkett
Applicant's signature (must be signed in the presence of a notary)

Burkett
Applicant's printed last name

Donna L.
Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

6/28/2013
Date of signature (must correspond to date of notarization)

Notary

State of NORTH CAROLINA, County of BUNCOMBE,

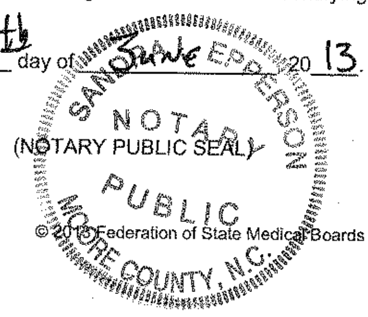
I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 28th day of June 20 13.

Notary Public Signature: Sandra S Epperson

My Notary Commission Expires: 12-7-2013

(NOTARY PUBLIC SEAL)



© 2013 Federation of State Medical Boards

DONNA L. BURKETT, MD

Curriculum Vitae
Affiliate Medical Director
Planned Parenthood Health Systems, Inc.
603 Biltmore Ave.
Asheville, NC 28801
Cell phone
Email

EDUCATION

1995-1998 Residency in Family Medicine, Oregon Health Sciences University (OHSU), Portland, OR. See below for detail.

1991-1995 Medical Degree, University of North Carolina School of Medicine, Chapel Hill, NC

1986-1990 B.S. Chemistry/B.A. French, Mars Hill College, Mars Hill, NC

EMPLOYMENT

Anticipated Sept 2013 **Medical Director, Planned Parenthood of Northern New England**

Feb 2011-present **Consultant, Planned Parenthood Federation of America**, Medical Services Department, writing and editing Primary Care Standards and Guidelines

July 2006- Aug 2013 **Affiliate Medical Director, Planned Parenthood Health Systems, Inc**, Regional Planned Parenthood in NC, SC, VA and WV. Duties include:

- Oversight and evaluation of physician and clinical employees
- Quality and risk management oversight for high-risk services in 12 health centers through 4 states
- Protocol review and oversight
- New clinical program innovation and implementation

July 2005-May 2013 **Part-time faculty, MAHEC Family Health Center**, Asheville, NC. Duties include:

- Starting and running vasectomy clinic
- Precepting residents in Family Practice clinic
- Participating in Obstetrical call
- Some didactic responsibilities for the reproductive health curriculum

February 2005 – June 2005 Family leave/volunteer at ABCCM, local free clinic

2001-2005 **Family Physician and Administrative Physician, WNC OB-Gyn and Family Practice**, Asheville, NC. Activities included:

- Established FP side of practice and built a very busy practice over several years
- Scope of practice included care of men, women, and children, primary gynecological care, obstetrical care, vasectomy, circumcision, and minor dermatological care and procedures
- As a partner, took on the administration of a failing practice and brought it into improved fiscal conditions through hiring better qualified management staff, changing billing system to more up-to-date one and internalized billing, bringing the AR DSO from 90+ to 40-50 in 1-year period, developing standard practices for quality and efficiency in the practice
- Established a teaching vasectomy service
- Periodically provided abortions at a partner's private practice

Jan 2000 – April 2001 Family Leave/volunteer as Preceptor at OHSU Family Medicine Department prior to move to NC

1996 - 2000 **All Women's Health Center**, Portland and Eugene, OR. Part-time, contractual, abortion procedural work in a non-profit reproductive health organization.

1998 - 1999 **Family Practitioner, North Portland Clinic, Providence Health System**, Portland, OR. Full-time clinician in an underserved community clinic. Duties included:

- Active obstetrical practice
- Call, hospital management of patients
- Chair – End of Life Improvement committee
- Participant – several medical informatics endeavors

July and August 1998 Extended vacation, following residency

1995- 1998 **Family Practice Resident, OHSU**, Portland, OR. Full-time. In-patient, out-patient, surgical, rural and urgent care rotations. Extra duties:

- Chief Resident 1997-1998 – scheduling, arranging conferences, teaching, and trouble-shooting
- Writing Abortion Curriculum for Ob/Gyn and Family Practice Residents in conjunction with Faculty Director

ADDITIONAL EDUCATIONAL EXPERIENCE

2004-2005	**Advanced Life Support in Obstetrics (ALSO) Instructor Course and Instructor Candidate** teaching completed, American Academy of Family Physicians (AAFP). Adult learning model utilized.
2003	**Fundamentals of Management Course**, AAFP. An intensive program designed to train FPs to become more effective managers and leaders.
Spring 1988	**Semester Abroad, Institute d'Etude Francais**, Avignon, FRANCE

PROFESSIONAL MEMBERSHIPS

2011-present Member, WPATH (World Professional Association of Transgender Health)
1998-present Diplomate, American Board of Family Practice
1998-present Member, American Academy of Family Physicians
2006-present Member, Association of Reproductive Health Professionals
2001-present Member, NC Academy of Family Physicians
2001-5, 2012 –present --Member, Western North Carolina Medical Society
1992-2002 Member, American Medical Women's Association

VOLUNTEER SERVICE

2010 -- present	Member, Medical Advisory Board, AFAXYS
2012 – present	Member, Federation Patient Safety Committee, ARMS, Inc
2008 – present	Multiple short-term committees, PPFA
2005-2012	Board Member of children's school, serving preschool through 8th grade. Chair 2008-2011. Led the school through a director transition and through implementation of Policy Governance.
2003 – present	various volunteer activities, same school
2005 – present	Reproductive health educator, various schools and church

INTERESTS AND ACTIVITIES

Knitting, cooking local foods, gardening, traveling

REFERENCES

Available upon request

Oregon

John A. Kitzhaber, MD, Governor

Medical Board
1500 S.W. 1st Ave., Suite 620
Portland, OR 97201
Voice (971) 673-2700
FAX (971) 673-2670
Web: www.oregon.gov/OMB

Verification of Licensure

July 14, 2013

This is to certify that the records of the Oregon Medical Board indicate the following information regarding:

Licensee:	Burkett, Donna Lynn, Dr.
Birth Year:	[redacted]
Gender:	Female
Mailing Address:	Wnc Obgyn And Family Practice 16 McDowell St Asheville, NC 28801
Basis of Licensure:	USMLE
School:	U/NC SCH/MED
School Location:	CHAPEL HILL, NC, United States
Graduation Date:	05/14/1995
*Disciplinary Standing:	Unrestricted *Please read explanation below*
License Number:	MD20096
Status:	Surrendered
Status Limitations:	
Date Issued:	10/18/1996
License Type:	MD License
Expedited Endorsement:	No
Specialty:	Family Practice
Dispensing Physician:	No
License Type:	MD Postgraduate License
Expedited Endorsement:	No
Specialty:	Family Practice
Dispensing Physician:	No

Other Licenses:	**From:**	**To:**
LL06837	07/01/1996	06/30/1997

** IMPORTANT - PLEASE READ*

- "Disciplinary Standing" refers to whether or not the Oregon Medical Board has ever taken a formal action against a Licensee. Such actions are taken via a document called a Public Order. If the "Disciplinary Standing" field above says "Public Order on File," "Prior Action," or "Revoked," it means that the Board has taken formal action against this Licensee and your Board is entitled to receive free copies of all related Public Orders. These orders will be sent to you directly by the Oregon Medical Board via US mail within 2-4 working days from the date of this verification.
- If the "Disciplinary Standing" field says "Unrestricted," that means that the Board has never taken any formal action against the Licensee in question and, as a result, there are no Public Orders on file.

State of West Virginia
Board of Medicine

101 Dee Drive, Suite 103
Charlston, WV 25311
Telephone 304.558.2084
www.wvbom.wv.gov

REV. O. RICHARD BOWYER
PRESIDENT

MICHAEL L. FERREBEE, M.D.
VICE PRESIDENT

MARIAN SWINKER, M.D., M.P.H.
SECRETARY

ROBERT C. KNITTLE
EXECUTIVE DIRECTOR

VERIFICATION OF LICENSURE

July 05, 2013

This is to verify that

DONNA L. BURKETT

was issued license number PMD22710 on May 14, 2007 to practice as a Physician and Surgeon in the state of West Virginia.

She was licensed by USMLE.

Dr. BURKETT granduated from University of North Carolina at Chapel Hill School of Medicine on May 14, 1995.

The current licensure status is ACTIVE and expires on June 30, 2014.

According to our records, this license HAS NOT been encumbered in this state.

This license information was last updated on: 07/04/2013

Robert C. Knittle, Executive Director

Lawler, Kelly

From:	verifications@ncmedboard.org
Sent:	Friday, July 05, 2013 5:31 PM
To:	Lawler, Kelly
Subject:	North Carolina License Verification for Dr. Donna Lynn Burkett

North Carolina Medical Board

07/05/2013

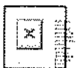
Name	Donna Lynn Burkett, MD
Renewal Date	01/10/2014
Public Action	No
Pending Investigation(s)	No

License Number	License Type	Issue Date	Current Status	Expire Date
200100124	MD	02/12/2001	Active	

Public Actions can be found on our website. Go to www.ncmedboard.org and then select 'Look up a Licensee' under Quick Links.
To receive certified copies of Public Actions, please email legal@ncmedboard.org.
If you have questions regarding Pending Investigation, email don.pittman@ncmedboard.org.

For general Verification questions, email verifications@ncmedboard.org.

Sincerely,



R. David Henderson
Executive Director

COMMONWEALTH of VIRGINIA

JUL 29 2013

VERIFICATION

Re: **Donna Lynn Burkett**

From: Virginia Board of Medicine

Subj: Licensure Verification

Date: July 23, 2013

This is to certify that the above named individual was issued a license to practice by the Virginia Board of Medicine:

Licensed in/as a:	**Medicine & Surgery**
License:	**0101241288**
Issued on:	**02/23/2007**
Expires:	**01/31/2014 ***

This license has not been the subject of an administrative proceeding. If you have any questions, please call 804-367-4451.

The information above is the only verification provided by this board. If other information is needed, please do not hesitate to contact this office. To expedite the verification process, the above format is the standard format prepared for all professions regulated by this board.

Verifications may also be obtained from our website at www.dhp.virginia.gov or our interactive phone system at 804-270-6836 with fax back option.

* The expiration date of 1956 indicates that there is no recorded date of expiration for this license, and that it expired sometime prior to 1980.

Sincerely,

Alan Heaberlin

Deputy Director-Licensure
Virginia Board of Medicine

NOTE: The Board of Medicine no longer provides a raised seal on this document.

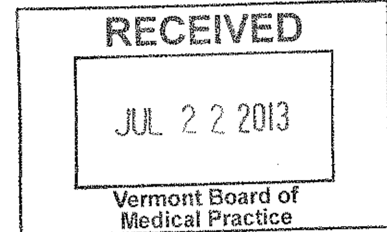
South Carolina
Department of Labor, Licensing and Regulation

Nikki R. Haley
Governor

Holly G. Pisarik
Director

Board of Medical Examiners

110 Centerview Drive
Post Office Box 11289
Columbia, SC 29211-1329
(803) 896-4500
FAX: (803) 896-4515
www.llronline.com/pol/podiatry



License Verification

Vermont Board of Medical Practice
108 Cherry Street
Burlington VT 05401

Name: Donna L Burkett **Profession:** M.D. **Office Phone:** (828) 252-7928 X6237

Birth Date: [redacted] **Specialty:** FP* N

License No: MD 29999 **Date Issued:** 09/21/2007 **Expiration:** 06/30/2015

Basis: US 1996 **School:** NC **Graduated:** 05/14/1995

Primary Source Verification of Graduation Certified

Hospital Affiliation (s):

Status: ACTIVE

***Please Note: Due to a new computer system, all limited and temporary license numbers have been changed. Although there is a unique license number listed above, the information is verifying license number .

No disciplinary action taken by this Board. This certifies that the above licensee is in good standing.

License History:
Temporary License Number:
Temporary License Issue Date: 06/15/2007
Limited License Number:
Limited License Issue Date:

Verified on 7/16/2013 by:

Cameron Moore, Administrative Assistant

Unresolved disciplinary actions currently pending before the boards will not be included in the information presented. Reported discipline of licensees indicates the final disposition of contested cases, but may not reflect the current status of a license. Licensees are fully authorized to practice their professions unless their licenses have been restricted, suspended, revoked, deactivated or voluntarily surrendered. Licensees on probation may have been placed under certain professional restrictions which may limit the scope of their practice. Also, board actions reported here may not reflect any subsequent judicial actions to stay or modify the board's decision.

American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

July 15, 2013

To Whom It May Concern:

This letter verifies Donna Lynn Burkett, M.D. (NPI: 1760445506) is currently certified with the American Board of Family Medicine (ABFM).

Family Medicine Certification History:

Jul 10, 1998 - Jul 22, 2005
Jul 23, 2005 - Dec 31, 2015*

* Three Year extension of certification earned by completion of MC-FP requirements.

Maintenance of Certification for Family Physicians (MC-FP):

Current Status: Meeting Requirements

Beginning in 2004 with the family physicians who performed successfully on the Certification and Recertification examinations in 2003, the ABFM began a gradual transition from Recertification to Maintenance of Certification for Family Physicians (MC-FP). MC-FP was designed to transition all Diplomates into the program by 2010, enrolling all physicians who certified or recertified as they successfully passed the examination.

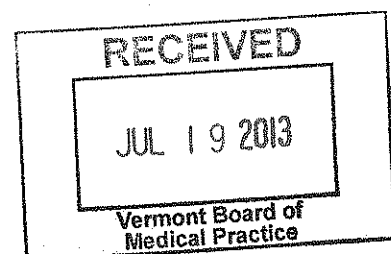
The MC-FP program is divided into separate three-year stages. By completing Stage 1 and Stage 2 by specified deadlines, the life of a certificate will be extended from seven to ten years. Diplomates who are unable to complete these requirements will retain their original seven-year certificate. Regardless of whether a Diplomate is on a 10-year or 7-year cycle, MC-FP requirements must be completed prior to applying for the next MC-FP examination. The prior requirements for licensure and CME are incorporated into the requirements of MC-FP.

The ABFM website serves as primary source verification. Details of the MC-FP process are available online at www.theabfm.org.

Sincerely,

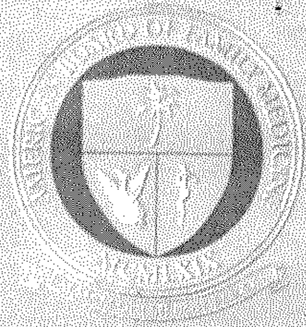
Mary McIntosh

Mary McIntosh
Verification Coordinator and Candidate Assistant



1648 McGrathiana Pkwy, Ste. 550 | Lexington, KY 40511-1247 | Ph: 859-269-5626 or 888-995-5700 | Fax: 859-335-7516 | www.theabfm.org

American Board of Family Medicine, Inc.



Donna Lynn Burkett, M.D.

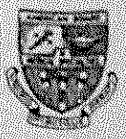
is a Diplomate of this Board and
having met its continuing requirements is hereby

Recertified

as a

Diplomate

2005-2015



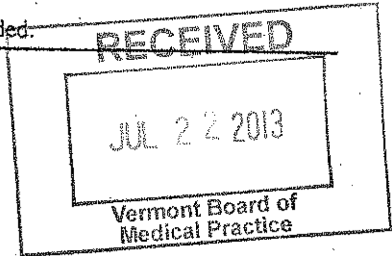
Chair

President

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: Donna Lynn Burkett, MD

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. Alan M. Johnson was at Mission Hospital
From 7-19-2001 to 5-31-2013. During that time, he/she was (List status in the Institution): Active - Family Medicine

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: Donna Lynn Barkett, MD

How long have you known the applicant and in what capacity? 12 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?	✓	

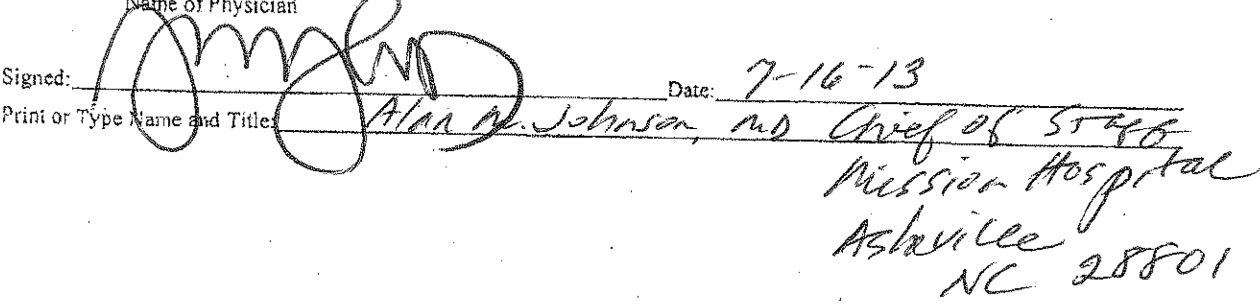
In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluation this applicant. Of particular value to us in evaluating any candidate are comments 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: Credentials File

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 Dr. Donna L. Barkett for licensure in Vermont.
Name of Physician



Signed: [signature] Date: 7-16-13

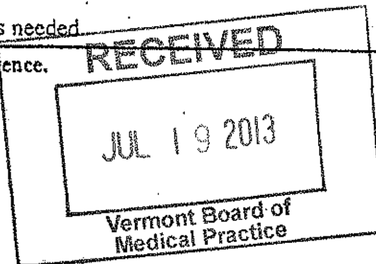
Print or Type Name and Title: Alan [illegible]. Johnson, MD Chief of Staff Mission Hospital Asheville NC 28801

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: Donna Burkett, MD

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. Donna Burkett was at Mountain Area Health Education Center
From July 2005 to May 2013. During that time, he/she was (List status in the Institution): Faculty Physician

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: Donna Burkett, MD

How long have you known the applicant and in what capacity? 8 years - Partner / 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.

Experienced Family Physician and Educator.

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 Donna Burkett, MD for licensure in Vermont.
Name of Physician

Signed: Stephen Hulkower MD Date: 7/15/13

Print or Type Name and Title: Stephen Hulkower MD
Director, Division of Family Medicine
Mountain Area Health Education Center
Asheville, NC.

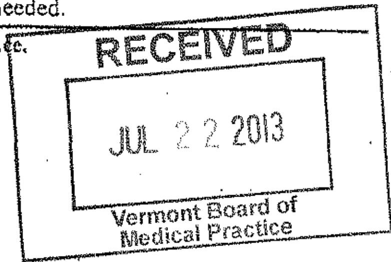
Addendum 4A

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: Donna Burkett, MD

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. Donna Burkett was at MAHEC, Asheville NC

From July 2005 to May 17, 2013. During that time, he/she was (List status in the Institution): faculty @ MAHEC residency program

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: Donna Burkett

How long have you known the applicant and in what capacity? 1995 → present 1995 - 2005 knew Donna b/c we graduated from same residency 2005 - 2013 we were partners in MAHEC faculty

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: ___

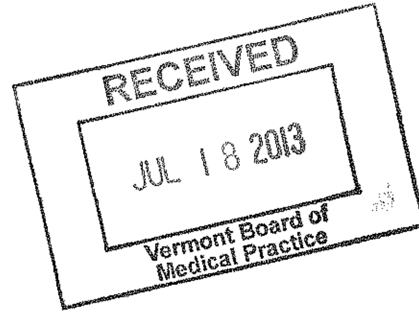
I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend Donna Burkett (Name of Physician) for licensure in Vermont.

Signed: [signature] MD Date: 7/16/13

Print or Type Name and Title: Lisa Ray MD

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE



Medical Professional Information Profile

This report provides credentialing information for

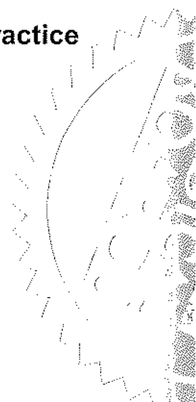
Name: **Donna Lynn Burkett**

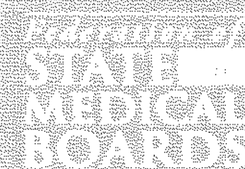
Social Security: Number: [redacted]

Date of Birth: [redacted]

FID#: **212747208**

Recipient: **VT - Vermont Board of Medical Practice**





ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the *Institution issuing such document. FCVS maintains all original documents (excluding third-party* examination transcripts) in the physician's source file.

This FCVS medical professional Information Profile ("Profile") is compiled and provided by the Federation of State Medical Boards of the United States, Inc. (Federation) as a reference source for, and only for, its member boards and other entities authorized by the Federation. The Profile embodies and contains confidential business information because the information, and the format and presentation of that information, comprise trade secrets of the Federation and because the Profile's disclosure would harm the Federation by providing others with an unfair business advantage in competing with the Federation's FCVS services. Further, the form of the Profile and the contents of this Profile, including the compilation of information in this Profile, are the Federation's copyrighted works and proprietary, confidential information and are subject to the protections of United States laws governing copyright, trademark and trade secrets, as well as various state laws protecting the Federation's trade secrets and other intellectual property rights. This Profile and its contents may not be (1) copied, reformatted, modified, published or displayed publicly or (2) used, disclosed, distributed, shared or sold, in whole or part, for any purpose, including use to establish any database or files as a compendium or otherwise, all of which is strictly prohibited without the express written consent of the Federation's CEO.

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Credentials Analysis Summary Report

Note: *Your board may wish to review the unresolved items below marked by an "X"*
Please review the Credentials Analysis report for further details on the unresolved items

Medical Professional Name: **Donna Lynn Burkett**
Date of Birth: [redacted]
Social Security Number: [redacted]
FID: **212747208**

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

A. Certified Birth Certificate

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

University of North Carolina at Chapel Hill School of Medicine
X 1. Medical Education Form
2. Medical Education Dean's Letter
3. Medical Education Transcript
4. Medical Education Diploma

C. Fifth Pathway Program

D. ECFMG Certification

V. Graduate Medical Education

Oregon Health Sciences University
1. GME Form
2. GME Completion Certificate

VI. Licensure Examination History

A. FSMB Exams

End of report for: Donna Lynn Burkett

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C. Chronology of Activities

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B. American Board of Medical Specialty Verification

III. Identity

A. Affidavit
B. Certified Birth Certificate or Original Passport
C. Documentation to Support Name Variation

IV. Medical Education

A. Verification of Medical Education
B. Clinical Clerkships (if applicable)
C. Verification of Fifth Pathway (if applicable)
D. ECFMG Certification (if applicable)

V. Graduate Medical Education

A. Verification of Graduate Medical Education

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A. LMCC Transcript
B. State Medical Board Transcript
C. NCCPA Transcript
D. NBME Transcript
E. NBOME Transcript
F. FSMB Transcript

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Section I

FCVS Reports

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Medical Professional Information Report

Identity

Medical Professional Name: **Donna Lynn Burkett**

Documentation: Certified Birth Certificate

Gender: Female

Date of Birth: [redacted]

Place of Birth: Hattiesburg, MS, UNITED STATES

Social Security Number: [redacted]

FID: 212747208

Physical Description:

Height:	5 ft. 9 in.
Weight:	145 lbs.
Eye Color:	Brown
Hair Color:	Brown

Contact Information

Mailing Address: 603 BILTMORE AVE
ASHEVILLE, NC 28801-4603
UNITED STATES

Permanent Address: [redacted]

Telephone Numbers:

Primary:	[redacted]
Secondary:	N/A
Fax:	(828) 255-8187
Other:	N/A

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Premedical Education

(Provided by Applicant. Not verified with the primary source.)

Institution: **Mars Hill College**
Address: Mars Hill, NC 28754
UNITED STATES
Dates of Attendance: 08/--/1986 To 05/--/1990
Degree Conferred/Issued: Master of Science

ECFMG

There are none identified or not applicable.

Medical Education

Medical School: **University of North Carolina at Chapel Hill School of Medicine**
Address: 1001 Bondurant Hall, CB# 9535
Chapel Hill, NC 27599-9535
UNITED STATES

Dates of Attendance: 08/21/1991 to 02/24/1995
Date Certificate Issued: 05/14/1995
Degree Conferred/Issued: Doctor of Medicine

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Fifth Pathway

There are none identified or not applicable.

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Graduate Medical Education

Institution: **Oregon Health Sciences University**
Address: 3181 SW Sam Jackson Park Road

Portland, OR 97201-3098
UNITED STATES

Training Level: 1
Program Type: Internship
Specialty: Family Medicine
Dates of Attendance: 07/01/1995 To 06/30/1996
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 2
Program Type: Residency
Specialty: Family Medicine
Dates of Attendance: 07/01/1996 To 06/30/1997
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 3
Program Type: Residency
Specialty: Family Medicine
Dates of Attendance: 07/01/1997 To 06/30/1998
Completed Successfully: Yes
Accreditation: ACGME

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

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Licensure Examinations

FSMB Transcript USMLE Step 1	Date: 06/1993	Passed the Exam
FSMB Transcript USMLE Step 2 CK	Date: 03/1995	Passed the Exam
FSMB Transcript USMLE Step 3	Date: 05/1996	Passed the Exam

ABMS Verification

A report of the result from a search of the data provided by the American Board of Medical Specialties is enclosed.

Board Action

A report of the results from a search of the Board Action Data Bank is enclosed.

End of report for Donna Lynn Burkett FID: 212747208

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The Credentials Analysis Report is a comparative report of a medical professional's credentials as reported to FCVS by the applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Medical Professional Identification

Medical Professional Name: **Donna Lynn Burkett**

Date of Birth: [redacted]

Social Security Number: [redacted]

FID: **212747208**

Omissions

There are no omissions identified.

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Discrepancies

Discrepancy 1:

Section of Profile: **Medical Education**

Discrepancy: **The applicant reports attendance at University of North Carolina at Chapel Hill School of Medicine from 08/--/1991 to 05/--/1995. The institution reports attendance from 08/21/1991 to 02/24/1995.**

Action Taken: **FCVS has contacted the applicant in an attempt to resolve the attendance date discrepancy. The applicant has verified the date information reported is accurate according to their records.**

Miscellaneous Information

There is no miscellaneous information identified.

End of report for: Donna Lynn Burkett

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Chronology of Activities

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS by the medical-professional applicant.

Medical Professional Name: **Donna Lynn Burkett**
Date of Birth: [redacted]
Social Security Number: [redacted]
FID#: **212747208**

Start Date	End Date	Activity	Location	Overlap Explanation	Program Length Explanation
8/1991	05/1995	Medical Education Record	University of North Carolina at Chapel Hill School of Medicine,1001 Bondurant Hall, CB# 9535 Chapel Hill, NC 27599-9535 UNITED STATES		
7/1995	06/1998	GME Record	Oregon Health Sciences University,3181 SW Sam Jackson Park Road Portland, OR 97201-3098 UNITED STATES		

End of report for Donna Lynn Burkett

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Section II

FSMB and Other Reports

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FPDC | FEDERATION PHYSICIAN DATA CENTER

Board Action Clearance Report

STATE MEDICAL BOARDS

July 15, 2013

Attn: Tracy Bevers
FCVS
400 Fuller Wiser Rd., #209
Euless, TX 76039

Re: Board Action Query Dated: July 15, 2013
FSMB Batch Number: BQ2293709

The following is a report of the search results from the Board Action Data Bank as of July 15, 2013 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Provider cleared with No Actions as of July 15, 2013

Name	DOB	School	Yr/Grad	Provider ID
Donna Lynn Burkett	[redacted]	034040	1995	73923

License History

Licensing Entity
NORTH CAROLINA
OREGON
SOUTH CAROLINA
VIRGINIA
WEST VIRGINIA

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes

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ABMS Verification of Certification

As of: **07/15/2013**
Medical Professional Name: **Donna Lynn Burkett**
Date of Birth: [redacted]
Year of Graduation: **1995 (Doctor of Medicine)**
ABMSUID#: **590758**

Certification

Certification:

Board: Family Practice
Specialty: Family Practice
Status: ACT
Initial Certification: 07/10/1998

End of report for Donna Lynn Burkett

All certification information on the ABMS report is based on a search of data shared with the FSMB by the American Board of Medical Specialties. For some physicians the biographic data in the ABMS database is incomplete and is not included in the shared data. FCVS is unable to verify specialty certification on these physicians. FCVS does not follow up with the applicant or ABMS on any missing or discrepant information.

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Section III

Identity

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Federation of STATE MEDICAL BOARDS

Affidavit and Release and Authorization for Release of Information, Documents and Records

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true; that I am the original and lawful possessor 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 "Instructions for Completing the FCVS Application" 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 waive confidentiality, 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 Federation Credentials Verification Service (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, 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 FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to any FCVS Physician Information Profile being mailed.

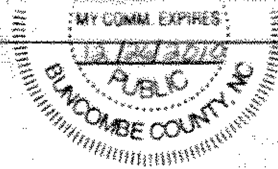
Donna L. Burkett
Applicant's Signature (must be signed in the presence of a notary)

Burkett
Applicant's Printed Last Name

Donna L.
Applicant's Printed First Name, Middle Initial and Suffix

3/21/07
Date of Signature

Date of Birth



NOTARY

Your seal or stamp must be partly upon the photograph.

State of North Carolina County of Buncombe

SUBSCRIBED AND SWORN TO before me this 21 day of March, 2007

My commission expires 12-26-2010

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature: Jean C. Handy

I certify that on the date set forth above the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

Section IV

Medical Education

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FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of North Carolina at Chapel Hill School of Medicine

Complete Address: Registrar

Street Address: 1001 Bondurant Hall, CB# 9535

City: Chapel Hill **State:** NC **ZIP Code (Postal Code):** 27599-9535

If name of institution was different when this individual attended, please note this name below:

____

Premedical Education:

Years of education required for admission to your medical school: 4 undergraduate

Credential/degree presented by the applicant for admission to your medical school: BH Mars Hill College

Enrollment and Participation: Our records indicate that Donna Lynn Burkett
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 147 weeks of medical education on the following dates (mm/dd/yy):

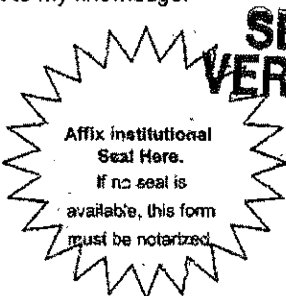
From Aug / 21 / 1991 (Month / Date / Year) **To** Feb / 24 / 1995 (Month / Date / Year)

This individual (check one):

Was awarded the degree of Doctor of Medicine on May / 14 1995 (Month / Date / Year)

Was NOT awarded a degree because: ______________________________
(please explain - attach additional pages if necessary)

Certification: By my signature, I, Forrest H. Page (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.



SEAL VERIFIED

Signature: [signature]

Title: Registrar

Date of Signature: April 18, 2007

Phone: (919) 962-8335 **Fax:** (919) 966-9930

Email: ______________________________

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)
(continued)

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during **any part** of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?

   Response YES ☐ NO ☒ x

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify: __________

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response YES ☐ NO ☒ x

   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify reason: __________

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response YES ☐ NO ☒ x

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports or an investigation by the medical school or parent university? Response YES ☐ NO ☐ x x

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?

   Response YES ☐ NO ☒ x

   If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

Applicant Reported Unusual Circumstances

Medical School

Medical Professional Name: Donna Lynn Burkett
University of North Carolina at Chapel Hill School of Medicine

Unusual Circumstances

Question		
Did you have any interruption(s) or extension(s) in your medical education?	Yes	**No**
Were you ever placed on probation?	Yes	**No**
Were you ever disciplined or placed under investigation?	Yes	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for Donna Lynn Burkett

PROVIDED BY APPLICANT

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The School of Medicine
The University of North Carolina at Chapel Hill
Chapel Hill, North Carolina 27599-7000

GRADING SYSTEM

Grades for each course were given beginning with the first year class which entered in the fall of 1984. Prior to that, only year-end summary grades of Honors, Pass or Fail were recorded.

Grades used in the first two years:

H	Honors, clear excellence
*HP	High Pass, above average
P	Pass, entirely satisfactory
F	Fail, failed
BE	Credit by Examination
NG	No Grade, assigned administratively to those courses which extend over more than one semester and for which no fall semester grade is given.
W	Withdrew from course, assigned administratively when dropped prior to final grade given.
*HP	available for first year courses in academic year 1988-89 available for second year courses in academic year 1989-90

Added to these for the THIRD year (in 1986) and FOURTH year (in 1987) were.

HP	High Pass, above average
* LP	Low Pass, below average (Discontinued use after 1998-99 academic year)

Temporary Grades:

AB	Absent from examination
IN	Incomplete other then final examination
CO	Condition; final grade pending reexamination and/or limited additional academic work

HONORS FOR THE YEAR

In the first two years, this grade is awarded to the top 15% of the class. No more than the top 25% of the third year and fourth year classes may receive this distinction for the year's work. The grade is assigned by the Student Promotions Committee based on performance in the given year weighted according to grades and hours in the curriculum.

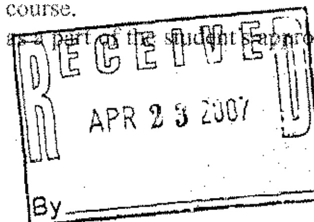
FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974

In accordance with the Family Educational Rights and Privacy Act of 1974, the information contained on this transcript shall not be released to any other party unless a written consent is obtained from the student.

LEGEND FOR SUPERSCRIPTS

1) Student chose to take this/these course(s) in a decelerated curriculum.
2) Student was required to remediate limited academic deficiencies by independent review of course material and retaking the examination.
3) Student was required to remediate limited academic deficiencies by performing additional classwork or clinical experience and/or retaking the examination.
4) Student was required to take this/these course(s) in a decelerated curriculum.
5) Student was required to remediate identified academic deficiencies in a faculty supervised formal review and to retake the course examination.
6) Student was required to remediate academic deficiencies by repeating this entire course in a decelerated curriculum.
7) Student was required to remediate academic deficiencies by repeating this entire course.
8) Student chose to remediate academic deficiencies by repeating this entire course as a part of the student's approved program of study.

12/10/01



The University of North Carolina
at Chapel Hill

To all to whom these presents shall come

Greeting

Be it known that

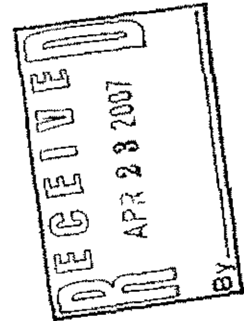
Donna Lynn Burkett

having completed the studies and fulfilled the requirements of the Faculty for the degree of

Doctor of Medicine

has accordingly been admitted to that degree, with all the rights, honors, and privileges thereunto appertaining.
In witness whereof, the Seal of the University and the signatures of duly authorized officers are affixed to this diploma.

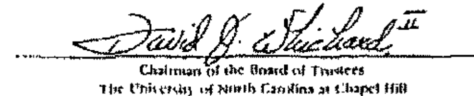
Given at Chapel Hill, in the State of North Carolina, this fourteenth day of May in the year nineteen hundred and ninety-five and of this University the two hundred and sixth.

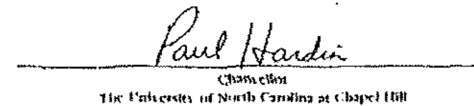


SEAL VERIFIED

Chairman of the Board of Governors
The University of North Carolina

President
The University of North Carolina


Chairman of the Board of Trustees
The University of North Carolina at Chapel Hill


Chancellor
The University of North Carolina at Chapel Hill

Dean

To Whom It May Concern:

Certified to be a true copy of a valid **DIPLOMA** from
The University of North Carolina at Chapel Hill.
Chapel Hill, North Carolina, U.S.A.

Forrest H. Page, Registrar
School of Medicine
University of North Carolina at Chapel Hill

North Carolina
Orange *County*

I, Donna Norton *, a Notary Public, do*

hereby certify that Forrest Page
personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal, this the 18 *day of* April
*20*07

(Official Seal) Donna Norton
Notary Public

My commission expires 10/10 *, 20*11.

SEAL
VERIFIE

Section V

Graduate Medical Education

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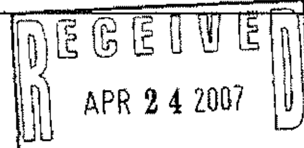
Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)
Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: Oregon Health Sciences University
Attention: **Program Director**
Address: Department of Family Medicine
Affiliated University: ____
Portland, OR 97239

Verification For:
Name: Burkett, Donna
SSN:
DOB



Individual's Name on Record (if different from above): ____

Program Participation:

Important:

Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotation.

PGY: 1 **Specialty/Subspecialty:** Family Medicine

- [x] Internship
- [ ] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

From: 7/1/95 **To:** 6/30/96

Successfully Completed?: [x] Yes [ ] No [ ] In Progress

Accredited by: [x] ACGME [ ] AOA [ ] LCGME [ ] RSC [ ] CFPC [ ] RCPSC [ ] APPAP [ ] None of these

PGY: 2 **Specialty/Subspecialty:** Family Medicine

- [ ] Internship
- [x] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

From: 7/1/96 **To:** 6/30/97

Successfully Completed?: [x] Yes [ ] No [ ] In Progress

Accredited by: [x] ACGME [ ] AOA [ ] LCGME [ ] RSC [ ] CFPC [ ] RCPSC [ ] APPAP [ ] None of these

PGY: 3 **Specialty/Subspecialty:** Fam Med

- [ ] Internship
- [x] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

From: 7/1/97 **To:** 6/30/98

Successfully Completed?: [x] Yes [ ] No [ ] In Progress

Accredited by: [x] ACGME [ ] AOA [ ] LCGME [ ] RSC [ ] CFPC [ ] RCPSC [ ] APPAP [ ] None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? [ ] Yes [x] No
2. Was this individual ever placed on probation? [ ] Yes [x] No
3. Was this individual ever disciplined or placed under investigation? [ ] Yes [x] No
4. Were any negative reports ever filed by instructors? [ ] Yes [x] No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? [ ] Yes [x] No

Please explain any "Yes" response from above:

____

____

Certification:

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Patrice Eiff, MD
Signature: [signature]
Title: Residency Director
Date of Signature: 4/12/07
Tel: 503 494-6610 Fax: 503 494-7659 E-Mail: Eiff@ohsu.edu

CMS

Rev. 09/07/05 Packet ID: 73923 Request ID: 17671397 (12) [13902]

Applicant Reported Unusual Circumstances

Graduate Medical Education

Medical Professional Name: Donna Lynn Burkett
Oregon Health Sciences University
Family Practice

Unusual Circumstances

Question		
Did you have any interruption(s) or extension(s) in your medical education?	Yes	**No**
Were you ever placed on probation?	Yes	**No**
Were you ever disciplined or placed under investigation?	Yes	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for Donna Lynn Burkett

PROVIDED BY APPLICANT

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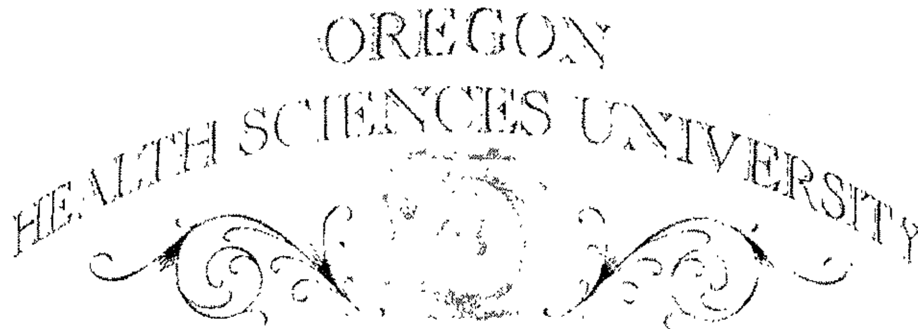


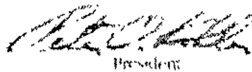
To all to whom this writing may come, Greeting:
Be it known that

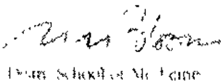
Donna L. Burkett, M.D.

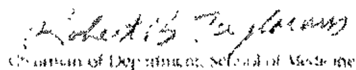
having acceptably fulfilled the duties of

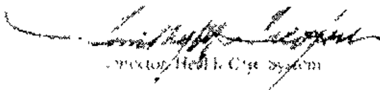
Resident in Family Practice

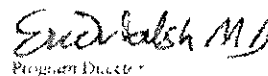
in the University Hospital and Clinics and affiliated Hospitals for a period of three years beginning July 1, 1995 and ending June 30, 1998 is hereby granted this Certificate in acknowledgment of services loyally performed with all rights and privileges due thereunto appertaining
Dated at Portland, Oregon, June 30, 1998.


President


Dean, School of Medicine


Chairman of Department, School of Medicine


Director, Health Care System


Program Director

Section VI

Licensure Examination History

(State Licensing Authorities Only)

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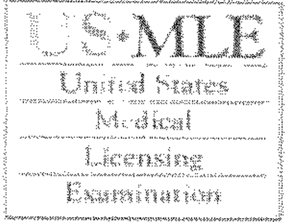

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 -- Telephone (817) 868-4000

Date : 07/09/2013

Recipient:

Federation Credentials Verification Service
ATTN: FCVS

Packet ID: 73923

Examinee ID#: 4-018-412-9
Examinee: Burkett, Donna Lynn
Date of Birth: [redacted]
Alt Name(s):

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

	Test Date	Pass/Fail	Total	MP	Comments
	06/08/1993	Pass	191	(176)	

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Total	MP	Comments
	03/01/1995	Pass	197	(167)	

USMLE STEP 3

	Test Date	Pass/Fail	Total	MP	Comments
OREGON	05/14/1996	Pass	206	(176)	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 -- Telephone (817) 868-4000

Examinee ID#: 4-018-412-9

Examinee: Burkett, Donna Lynn

Date of Birth: [redacted]

INTERPRETATION OF RESULTS

USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 2 CLINICAL SKILLS (CS)

Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. **No score is reported.** Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information.* Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Data Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

4/2013

The Federation of State Medical Boards
of the United States, Inc.
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
FAX (817) 868-4099

BOARD ACTION CLEARANCE REPORT

July 29, 2013

Vermont Board of Medical Practice
Attn: David K. Herlihy, JD
108 Cherry Street
PO Box 70
Burlington, VT 05402-0070

Re: Board Action Query Dated: July 29, 2013
Your Reference Number:
FSMB Batch Number: BQ2302753

The following is a report of the search results from the Board Action Data Bank as of July 29, 2013 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of July 29, 2013

Item	Name	DOB	School	Yr/Grad	Request ID
1	Burkett, Donna	01/10/1968	034040	1995	26879579

LICENSE HISTORY
State Board
NORTH CAROLINA
OREGON
SOUTH CAROLINA
VIRGINIA
WEST VIRGINIA

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

Renewal - 042.0012729

Name	Donna Lynn Burkett
Credential	042.0012729

Fee Details

Renewal	$500.00
	$500.00

Renewal Introduction

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

PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

Please follow the instructions below and submit the completed application with documentation and payment to this office. If you have any questions or need additional information do not hesitate to contact us at 802-657-4223, 800-745-7371 or medicalboard@state.vt.us.

IMORTANT: Your license will lapse if we have not received your completed application and fee by your expiration date. In addition, you will be subject to late renewal penalty fees and potentially liability if you practice medicine without a license.

INSTRUCTIONS

- do not delegate this important task to any other person. False statements on this application may be grounds for charges of unprofessional conduct.
- enter, correct or update all information
- answer all questions completely, even if you believe the information is already on file with the Board
- use Form A to provide explanations to Malpractice

Malpractice Claim Documentation – If you have reportable malpractice history, you must download Form A, carefully complete a form for each case, and submit it along with the required documentation. For your application, reportable malpractice includes:

- Pending claims that have not been resolved.
- Cases that resulted in a payment by you or on your behalf, whether as a settlement, arbitration award, or court verdict.
- Note that you need not report cases that were resolved in your favor with no payment by you or on your behalf. This includes cases that were withdrawn without payment, dismissed without payment, or resolved by a verdict in your favor.

Be sure to submit:

- completed Form A, if applicable
- payment in the amount of $500 to the **Vermont Department of Health**
- ***LATE FEE:*** Applications received after the license expiration date will be assessed a $25 late fee.

Please Note:

- Your Physician License Renewal Application has been pre-populated with information provided by and previously approved by you prior to the initial release of the Department's physician profiles. Please take this opportunity to correct any factual inaccuracies and/or update any information as appropriate.
- Licensees have a continuing obligation during each two-year renewal period to promptly notify the Board of any change or new information including, but not limited to, 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.

Thank you.

Renewal Part I

Name:

Indicate your full legal name (use no initials). 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. Last Name:
   Burkett

2. First Name:
   Donna

3. Middle Name:
   Lynn

4. Have you ever legally changed your name?
   No

5. If yes, enter your former name and other name(s):

Previous Name	From Month	From Year	To Month	To Year	Reason for Change

6. Date of Birth:

7. Please provide your preferred email address for receiving important correspondence from this medical board
   donna.burkett@ppnne.org

8. Enter your MAILING ADDRESS information:

Attention

Street

City **State** **Zip** **Country** United States

E-mail Address

Telephone **Alternate Phone (e.g. Pager)**

9. Enter your PUBLIC ACCESS address information:

Attention

Street 128 Lakeside Avenue, Suite 301

City Burlington **State** VT **Zip** 05401

Country United States

Telephone 802-448-9700

E-mail Address

Alternate Phone (e.g. Pager)

Renewal Part II

10. Were you in active clinical practice in the past 12 months?
    Yes

11. Do you hold, or have you ever held, a license or certification as a medical practitioner in any other state?
    Yes

12. If yes, complete the section below.

State	Profession	License Number	Issue Date	Expiration Date	Status
South Carolina	MD	29999	09/01/2007	06/30/2015	Active
Virginia	MD	0101241288	02/01/2007	01/31/2014	Not Renewed

North Carolina	MD	200100124	02/01/2001	01/10/2014	Not Renewed
Oregon	MD	MD20096	10/18/1996	01/01/2002	Not Renewed
West Virginia	MD	22710	05/14/2007	06/30/2014	Not Renewed
New Hampshire	MD	16261	08/07/2013	06/30/2015	Active
Maine	MD	MD19833	09/16/2013	01/31/2016	Active

13. Medical Professional Schools [26 VSA § 1368(a)(7)]
Please provide the names of medical professional schools you attended and the dates of graduation.

School	Graduation Date
School Name: University of North Carolina **State**: North Carolina **Country**: United States **School Type**: Medical School **Degree**: MD	05/30/1995

14. Graduate Medical Education/Residency [26 VSA § 1368(a)(8)]
Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Site Name	End Date	Specialty
Oregon Health Sciences University	06/30/1998	Family Practice

15. Specialty Board Certification [26 VSA § 1368(a)(9)]
Please verify the following information regarding your specialty board certification and update as necessary.

Specialty	Certification Board	Certification Date	Specialty Expiration Date
Family Practice	American Board of Family Medicine	07/01/1998	06/30/2015

16. **Years of Practice**
What year did you start practicing as a medical professional?
1995

17. **Hospital Privileges** [See 26 VSA § 1368(a)(11)]
List all hospitals where you currently have hospital staff privileges:

Facility Name	State	Start Date	End Date
Mission Hospital	North Carolina	10/01/2001	05/31/2013
Providence Health Systems	Oregon	08/30/1998	12/31/1999

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED.

18. Have you ever applied for and been denied a license or certificate to practice medicine or any other healing art in any jurisdiction? If yes, identify the US state or territory, or Canadian territory or province that denied the application and the year in which it was denied, and provide a summary of the circumstances and reason for denial, in the following questions. Upload documents related to the denial where indicated.
No

19. State:

20. Year:

21. Circumstances under which you applied and were denied a certificate to practice medicine or any other healing art:

22. Denied certificate to practice medicine or any other healing art - Upload documents

23. Have you ever withdrawn an application for a license or certificate to practice medicine or any other healing art, in any jurisdiction? If yes, identify the US state or territory, or the Canadian territory or province in which you withdrew the application and the year in which it was withdrawn, and provide a summary of the circumstances and reason for the withdrawal, in the following questions. Upload documents related to the withdrawal where indicated.
No

24. State:

25. Year:

26. Circumstances under which the application for license or certificate was withdrawn, specifying your reason or reasons for withdrawl

27. Withdrawal of application for license or certificate - Upload documents:

28. Have you ever voluntarily surrendered a license or certificate to practice medicine or any other healing art, in any jurisdiction, after having been notified of an investigation that had not yet been resolved or in lieu of disciplinary action? “Surrendered a license” includes any form of voluntary abandonment of the right to practice in a jurisdiction, regardless of the terminology used, and includes allowing a license to lapse after learning of an investigation by a licensing authority. If yes, identify the state, territory, or province in which you surrendered a license or certificate and the year in which it was surrendered or you resigned, and provide a summary of the circumstances in the following questions. Upload documents related to the surrender of license where indicated. NOTE: If you let a license lapse because you no longer practiced in a state, and you had no knowledge of a pending investigation by the licensing authority, that would not constitute surrender of your license.
No

29. State:

30. Year:

31. Circumstances:

32. Voluntary surrendered license or certificate to practice medicine or any other healing art - Upload documents:

33. Are you currently the subject of any disciplinary charges by, or has disciplinary or employment action ever been taken by, any governmental authority, hospital, health care facility, or professional medical association, other than matters that have already been identified in response to preceding questions. If yes, identify the entity bringing the charges or action, the date, the duration of any discipline or conditions, any action taken, and the circumstances in the following questions. Upload documents related to the charges or actions where indicated.
No

34. Name of entity involved:

35. Date:

36. Duration:

37. Action Taken (add all that apply):

38. Circumstances:

39. Disciplinary charges or actions - Upload documents:

40. Has any US or Canadian state, territorial, or provincial licensing board ever denied you the privilege of taking an examination to be licensed as a health care professional? If yes, identify the state, territory, or province that denied you the privilege and provide the circumstances of the denial in the following questions. Upload documents relating to the denial of the privilege of taking an examination where indicated.
No

41. State:

42. Circumstances surrounding denial of examination privileges and reason therefore provided by the board that denied you the privilege of taking an exam:

43. Denial of examination privileges - Upload documents:

44. Have you ever discontinued your education, training, or medical practice for a period of more than three (3) months, NOT including periods occurring solely during premedical education?

Yes

45. If yes, please explain, including the dates during which your education, training, or practice was discontinued.

1/2000 to 5/2001 - I took a hiatus from practice to have my second child and move my family across the country. I worked only per diem and very part-time jobs during this time.

46. Discontinued Education, Training, or Clinical Practice - Upload documents:

47. Have you ever been dismissed or suspended from, or asked to leave a training program before completion?

No

48. Training program(s):

49. Location of program(s):

50. Year:

51. Circumstances surrounding dismissal, suspension, or request for you to leave the training program(s) before completion?

52. Are you currently the subject of an investigation or peer review by any licensing authority, hospital, medical staff group, health care facility, professional association, or other body that has authority to take actions regarding: your right to practice medicine or any other healing art; your employment practicing medicine or any other healing art; or your professional qualifications (e.g., specialty board certification)? If yes, provide the name of the entity conducting the investigation, its location, the date you learned about the investigation, and the circumstances that triggered the investigation in the following questions and upload any relevant documentation you have such as a letter notifying you of the investigation where indicated.

No

53. Entity Investigating:

54. Location of entity investigating:

55. Date (month and year) your learned of the investigation?

56. Describe the event under investigation and the circumstances triggering the investigation:

57. Open investigation by licensing authority, hospital, medical staff group, health care facility, professional association, or professional certifying organization – upload documents.

58. Has your privilege to possess, dispense, administer, or prescribe controlled substances or other prescription medications or devices ever been suspended, revoked, denied, restricted, or surrendered as the result of an investigation or action by any governmental entity at any time? If yes, provide the entity that acted on your privilege to prescribe, the nature of the limitation or action, the date of the action, and a description of the circumstances underlying the action in the following questions, and upload any relevant documentation you have regarding the action where indicated.

No

59. Entity that took action on prescribing privileges:

60. Action taken:

61. Date of action taken regarding prescribing privileges:

62. Circumstances underlying action on prescribing rights:

63. Action taken on prescribing privileges – upload documents.

64. Are you presently a defendant in a criminal proceeding?
No

65. Court:

66. City and state:

67. Charge:

68. Description:

69. Status:

70. Date:

71. Defendant in criminal proceeding - Upload Documents:

72. Do you currently prescribe, or have you ever prescribed, prescription medication or devices solely in response to communication by computer or other electronic means? This does not include: initial admission orders for newly hospitalized patients; prescribing for patients of a physician for whom you have taken call; prescribing for a patient examined by a licensed advanced practice registered nurse or physician assistant, or other practitioner with whom you have a supervisory or collaborative relationship; continuing medication on a short-term basis for a new patient prior to the new patient's first appointment; or emergency situations in which the life or health of the patient is in imminent danger. Nor would this include the use of an electronic medical record or other system for entering and transmitting prescriptions.
No

73. If you answered yes to the preceding question, provide a general description of any prescribing you do in response to electronic communications.

Renewal Part III

PART III

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

Any "yes" response to the questions below must be fully explained.

74. To your knowledge, are you currently the subject of a criminal investigation that has not yet resulted in charges against you? If yes, provide the jurisdiction, a description of the matter under investigation, and the date you became aware of the investigation in the following questions.
No

75. Jurisdiction:

76. Description of matter under Investigation:

77. Date you became aware of Investigation:

78. Upload any documents you may have relating to the matter under investigation:

79. To your knowledge, are you the subject of an investigation by any other licensing or certification board that has not yet resulted in charges as of the date of this application? If yes, provide the board involved, the date you became aware of the investigation, and a description of the matter under investigation in the following questions and upload relevant documents where indicated.
No

80. Licensing or certification board conducting investigation:

81. Date of event(s) under investigation:

82. Nature of event(s) under investigation:

83. Pending licensing board investigation – upload documents.

MEDICAL DEFINITIONS

The following definitions are provided to assist you in answering the medical related questions:

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make and exercise reasoned medical judgements, 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 and 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 Physician Assistant 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.

84. 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?

85. In explaining "Yes" answer to the previous question, 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.

86. Please upload any documents you have that are relevant to this matter.

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

88. In explaining a "Yes" answer to the previous question, 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.

89. Please upload any documents you have that are relevant to this matter.

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

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

92. Please upload any documents you have that are relevant to this matter.

Medical condition, treatment, use of chemical or illegal substances:

93. Treating organization:

94. Address:

95. Telephone:

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

97. Dates of illness or dependency (from, to):

98. Dates of treatment (from, to):

99. Name of rehabilitation/professional assistance or monitoring program:

100. Address:

101. Telephone:

102. Contact person at Program:

Renewal Part IV

Statutory Profile Questions

In accordance with Vermont law, the Board of Medical Practice collects certain information from licensed or certified health care professionals and maintains it in a data repository that is made available to the public. 26 V.S.A. § 1368. The publicly-available data base is commonly referred to as the online profile. When licenses are issued to applicants, instructions are provided as to how to review and update the information provided for the online profile. Answering these questions is mandatory, except for certain optional questions. Those that are optional are clearly identified. Information collected for the statutory profiles may be considered by the Board in its review of the license application. Statutory profile information is displayed to the public for only ten years, but the questions are not time-limited and you must respond regarding your full history.

Applicants with other events or actions that must be reported (e.g., a criminal conviction) must provide documentation of each event. It is very important for the Board to receive copies of court papers, licensing authority decisions, or similar documentation, as noted below. The Board will not act on an application that lacks required documentation**. If any reportable event involves alcohol or drugs in any way, you must contact the Vermont Practitioner Health Program to arrange for an evaluation**. **The Board will not act on an application that is missing a required evaluation.** You may contact VPHP at (802) 223-0400. Information about VPHP is online at: **http://www.vtmd.org/health-professional-wellness-and-recovery-programs**.

103. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] Have you been convicted of any crime? This includes both misdemeanors and felonies; it includes crimes such as driving under the influence (DUI), but not non-criminal traffic offenses such as speeding or parking tickets. For purposes of this question, “convicted” means that you pleaded guilty or were adjudged guilty by a court of competent jurisdiction. For this question, it also includes the loss of a driver’s license as a result of a civil process triggered by the refusal to provide a sample of breath for the purpose of screening for driving while under the influence of alcohol.

No

104. **Criminal Convictions continued** [See 26 VSA § 1368(a)(1)] Provide information regarding each conviction as defined above. **In addition to entering the information here, you must submit copies of documents that show information about the crime (s) of which you were convicted and the sentence imposed, to include the police report, any ticket/citation/indictment/arrest record, and final disposition.**

Date of Conviction	Court of Conviction	City	State	Description

105. Nolo Contendere/Matters [See 26 VSA § 1368(a)(2)]
Have you ever had a criminal involvement that resulted in a case resolved by a plea of “nolo contendere,” or where after finding facts that would establish guilt the matter was continued by the court in lieu of a conviction?

No

106. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]
Provide information regarding each criminal involvement resolved by a plea of “nolo contendere,” or where after finding facts that would establish guilt the matter was continued by the court in lieu of a conviction.

Date of Charges	Court	City	State	Description of Charges

107. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)]
Have you ever been served charges by, or been the subject of an order by the Vermont Board of Medical Practice or other Vermont professional licensing authority? (This includes stipulations, consent orders, or other voluntary resolutions that you accepted after being notified of an investigation, even if no charges were served.)

No

108. Vermont Board of Medical Practice Matters continued [See 26 VSA § 1368(a)(3)]
Provide information regarding each instance in which you were charged by, or were the subject of an order by the Vermont Board of Medical Practice or other Vermont professional licensing authority, including the findings, conclusions, orders, and final disposition of the matter by the courts, if applicable.

Date	Final Disposition Summary

109. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]
Have you ever been charged by, or been the subject of an order by a professional licensing or certification authority in any other US state or territory, or Canadian territory or province? (This includes stipulations, consent orders, or other voluntary resolutions that you accepted after being notified of an investigation, even if no charges were served.)

No

110. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]
Provide information regarding each incident in which you have been charged by or been the subject of an order by a professional licensing or certification authority in any other state, territory, or province. Provide documentation that shows the charges, findings, conclusions, and orders, plus final disposition by any court or appeal authority, if appealed.

Date of Disposition	Licensing Authority	City	State	Description of Disposition

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

111. Have you ever had hospital privileges revoked or involuntarily restricted for reasons related to competence or character?
No

112.
A. Revocation or Restriction of Hospital Privileges Information
Provide information about each instance in which hospital privileges were revoked or involuntarily restricted for reasons related to competence or character. Provide documentation that shows the date, basis for the action, the authority who took the action, and the action taken.

Date of Restriction	Hospital Name	State	Nature of Restriction	Reason for Restriction

113. Have you ever, after having been notified of an investigation or peer review that was not yet resolved, or in lieu of or in settlement of a pending disciplinary case related to competence or character, done any of the following:

resigned medical staff membership or privileges;

not renewed medical staff membership or privileges; or, -

consented to a restriction of hospital privileges?
No

114. B. Resignation or Nonrenewal of Medical Staff Membership, or Restriction of Privileges Information
Provide information about each instance in which you resigned or did not renew medical staff membership, or you had hospital privileges restricted, after having been notified of an investigation or peer review that was not yet resolved, or in lieu of or in settlement of a pending disciplinary case related to competence or character? Provide documentation that shows the date, the hospital, the basis for and nature of the case, and the terms of settlement, if any.

Date	Hospital Name	State	Action	Nature of Action	In Lieu or In Settlement

115. Medical Malpractice Court Judgments & Settlements Have you ever had a medical malpractice claim against you that is still pending or that resulted in any of the following:

- a court judgment against you; or

- an arbitration award or a settlement that you or another party paid on your behalf?

If you have any such cases, you must provide information as requested in the questions below. You must also complete a Medical Malpractice Case Information Form for each. The form is located **here** Download the form, fill it out completely, and upload it where indicated. A form must be completed and submitted for each case. You must also provide documentation for each case as explained on the form.
No

116. **A. Judgments**
Provide the information requested in the following table for each case in which there was a court judgment or arbitration award against you.

Date of Judgment	Number of Judgments

117. **B. Settlements**
Provide the information requested in the following table for each case in which you were named as a defendant and in which a settlement was paid by you or on your behalf.

Date Of Settlement

118. **C. Pending Cases**
Provide the information requested in the following table for each case that is currently pending against you.

Date

Appointments/Teaching [See 26 VSA § 1368(a)(12)]
Note: Providing the following Appointments and Teaching information 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.)

119. **A. Appointments** Please provide information about your appointments to medical school or professional school faculties.

School	City	State	Nature of Appointment	Year Started	Year Ended

120. **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	Year Started	Year Ended

121. Publications [See 26 VSA § 1368(a)(13)]
Note: Answering this question 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	Publication Date

122. Activities [See 26 VSA § 1368(a)(14)]
Note: Answering this question 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.

Activity or Award

123. Provide information about each current and planned practice location, wherever located. Indicate which is planned to be your primary practice location.

Practice Name	City	State	Primary Practice	Languages	Accepts Medicaid?	Accepts New Medicaid Patients?
PPNNE - Topsham	Topsham	Maine	No		Yes	Yes
PPNNE - Sanford	Sanford	Maine	No		Yes	Yes
PPNNE - Portland Health Center	Portland	Maine	No		Yes	Yes
PPNNE - Biddeford	Biddeford	Maine	No		Yes	Yes
PPNNE - West Lebanon	West Lebanon	New Hampshire	No		Yes	Yes
PPNNE - Manchester	Manchester	New Hampshire	No	Spanish	Yes	Yes
PPNNE - Keene	Keene	New Hampshire	No		Yes	Yes
PPNNE - Exeter	Exeter	New Hampshire	No		Yes	Yes
PPNNE -Derry	Derry	New Hampshire	No		Yes	Yes
PPNNE - Claremont	Claremont	New Hampshire	No		Yes	Yes
PPNNE - Williston	Williston	Vermont	No		Yes	Yes
PPNNE - St. Johnsbury	St. Johnsbury	Vermont	No		Yes	Yes
PPNNE - St. Albans	St. Albans	Vermont	No		Yes	Yes
PPNNE - Rutland	Rutland	Vermont	No		Yes	Yes
PPNNE - Newport	Newport	Vermont	No		Yes	Yes
PPNNE - Middlebury	Middlebury	Vermont	No		Yes	Yes
PPNNE - Hyde Park	Hyde Park	Vermont	No		Yes	Yes
PPNNE - Brattleboro	Brattleboro	Vermont	No		No	No
PPNNE -Bennington Health Center	Bennington	Vermont	No		Yes	Yes
Planned Parenthood Northern New England - Barre Health Center	Barre	Vermont	No		Yes	Yes
Planned Parenthood of Northern New England -Burlington Health Center	Burlington	Vermont	Yes	Spanish	Yes	Yes

Statement of Good Standing

124.

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 either:

A. This does not apply to me because I don't have any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense, or

B. 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.

Yes

125. Date:
11/10/2014

Child Support, Taxes

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer these questions.

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)

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

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 taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

127. You must select one of the two statements below regarding taxes:
I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000.00 fine or both.)

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.

128. Social Security Number:

[redacted]

129. Date of Birth:

[redacted]

130. 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.

Yes

131. Date:

11/10/2014

Continuing Medical Education Requirements

Each applicant for renewal must certify that he or she meets the requirements for CME as indicated by one of the statements below, a – f. Note that for purposes of this certification, completion of an activity includes taking the steps necessary to receive credit and obtain documentation of completion. If you cannot certify that you are eligible to renew your license because one of the statements applies to you, then you must contact the Board of Medical Practice to discuss your renewal application. You are not required to submit documentation of your CME activities with your renewal application, but licensees are subject to audit and may be asked to submit such documentation during the next two licensing cycles (for this renewal, through November 30, 2018).

The Rules for Continuing Medical Education are available on the Board's website at:
http://healthvermont.gov/hc/med_board/documents/FinalCMERules10.1.12_000.pdf

a) I do not have to complete CME for this renewal because I was licensed as an MD in Vermont for the first time on or after December 1, 2013.

b) I was licensed as an MD for the first time in Vermont between December 1, 2012 and November 30, 2013. Accordingly, my requirement is to have completed at least 15 hours of qualifying AMA PRA Category 1 CreditTM CME and at least one of those hours was on one or more of the following subjects: hospice, palliative care, and/or pain management services. In addition, if I hold or have applied for a DEA number to prescribe controlled substances, at least one of the qualifying hours I completed was on the subject of safe and effective prescribing of controlled substances. I have completed the applicable requirements.

c) I have completed at least 30 hours of qualifying AMA PRA Category 1 CreditTM CME and at least one of those hours was on one or more of the following subjects: hospice, palliative care, and/or pain management services. In addition, if I hold or have applied for a DEA number to prescribe controlled substances, at least one of the qualifying hours I completed was on the subject of safe and effective prescribing of controlled substances.

d) I am a member of the armed forces of the United States and I was subject to a mobilization and/or deployment (or multiple mobilizations and/or deployments totaling) one year or more. Accordingly, I am not required to certify that I completed CME for this renewal.

e) I am a member of the armed forces of the United States and during the period from June 1, 2012 to November 30, 2014, I was subject to a mobilization and/or deployment (or multiple mobilizations and/or deployments totaling) less than one year. Accordingly, my requirement is to have completed at least 15 hours of qualifying AMA PRA Category 1 CreditTM CME and at least one of those hours was on one or more of the following subjects: hospice, palliative care, and/or pain management services. In addition, if I hold or have applied for a DEA number to prescribe controlled substances, at least one of the qualifying hours I completed was on the subject of safe and effective prescribing of controlled substances. I have completed the applicable requirements.

f) I have not completed the required CME for renewal, but I have submitted a make-up plan that I have signed and that was approved by the Executive Director of the Board.

132. I hereby certify that I have satisfied the Vermont Board of Medical Practice requirements for CME as indicated in the above statement. Select the one that best applies.

B

Workforce Survey

"Since 1999, the State of Vermont has been conducting a census of some professions every two years as part of relicensing. This has allowed us to monitor changes in Vermont's health care workforce. In 2012, the Legislature enacted a law to make work force data collection mandatory for all health care professions at license renewal as a necessary part of health care reform and planning for our health care future. We would like to thank you for your participation in this census."

You must complete the workforce survey before you may complete your application to renew your license. The mandatory workforce survey is accessed by clicking **here**

133. I hereby certify that I have completed the workforce survey per the above instructions
Yes

Renewal Payment

134. You must choose one of the following payment options to complete your application. Note: Your application will NOT be processed by the Medical Board until payment is received. If you are a commissioned officer on active duty in the armed forces, you must submit a copy of your current active duty orders.
Credit Card

Review