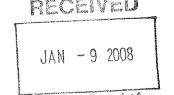
DEPARTMENT OF HEALTH BOARD OF MEDICAL PRACTICE 108 Cherry Street, PO Box 70 Burlington VT 05402-0070 802 657-4220 or 800-745-7371

PARTI



2008 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION tice

\cap	αrtifi.	data	#054	5	1071a

1	Name:	Stephanie	Reth	Stabl	$D\Delta$

2	Other Name(s), if a	ลทบ	under which	/OU Mere	certified of	r licenced i	n Varmant	and	alaauhara
۷.	Other Maine(s), ii c	2117,	unuel which	you were	Certified Of	i iicensea i	n vermont	and	-eisewnere:

Name: Stephanie Beth Stahl PA	
Other Name(s), if any, under which you were certified or licensed in Vermont at	nd elsewhere:
3. Work Address: 4th Floor ACC Main Pevillon 111 Colchate Due Burlinster, VT 05401	
City, State, Zip Cod	
Please check your preferred mailing address: Home Work (This address will be public and listed on the Board's webs	site)
5. Email Address	
6. Daytime Telephone Number: Area Code: 7. Date of Birth:	
B. Place of Birth:	
9. Certification Examination Taken – (Check box and enter date of examination):	
$\times (09/12/03)$ NCCPA	
□ (//) State Examination-Identify state:	
© (/) Other Examination specify:	
10. Basis for Vermont Certification – (Check box):	
□ Apprenticeship Trained University Trained	
l1. Do you have hospital privileges in Vermont? □ Yes'⊠ No	•

Hospital Name(s) and Location(s):	
12. In what year did you start working a	s a physician assistant in Vermont?
13. Did you practice in Vermont during	the past 12 months?
14. Other states where you now hold ar Ν/ μ	n active certification or license to practice:
15. States where you previously were c	ertified or licensed to practice:
16. Specialty: Women's Health	DEA Number: M51057408
17. Name and office address of current	EMPLOYER:
Name	Address
Flother Allen-Woman's MCS	_ III Colcheste Aug Burlington UTO 5401
18. Please list (use additional sheet if no as your PRIMARY and SECONDARY S	ecessary) name(s) and address(es) of physicians who currently serve SUPERVISING PHYSICIAN(S).
Primary Supervising Physician(s):	
Name	Address
Cherry Wors, Mo	4th Floor All, MP 111 Culchater Dove, Borlinston
Secondary Supervising Physician(s):	11 02401
Name	Address
Sie Alfafolia List	
physician(s) review the most current additions or deletions in duties and p	dical Practice requires that you and your primary supervising t scope of practice for your practice setting, paying attention to any procedures. Please review, date and sign your scope of practice and G PHYSICIAN sign it as well. Attach a copy of your signed scope of
a. Has there been a change in your □ Yes ፟፟፟፟ No	scope of practice which has not been reviewed by the Board?
 Please provide a letter from your Su Physician Assistant within the past t 	pervising Physician attesting to the fact that you have practiced as a welve months.

21. Continuing Medical Education (CME) requirements:

- a. NCCPA certified Physician Assistant: Attach proof of current NCCPA certification; this will serve as adequate proof of CME completion.
- b. For all others, an explanation of requirements and a CME Record form must be completed.
- 22. Primary Supervising Physician and Second Supervisory Physician forms are provided. They must be completed and returned with this application.

PART II

"Yes" answers to Questions 23 - 46 require an explanation on Form A.

- 23. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?
- 24. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?

25. Have you ever voluntarily suspended, surrendered or resigned a certificate to practice medicine or any other healing art in lieu of disciplinary action?

26. 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)?

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

28. Have you ever discontinued your education, training, or practice for a period of more than three months for reasons other than a family need?

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

30. 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?

31. 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?

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

PART III

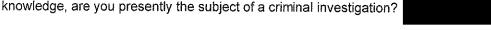
(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)

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

33. To your knowledge, are you the subject of an investigation by any other licensing board as of the date of Vermont Department of Health – Board of Medical Practice – 2008-2010 Physician Assistant Certification Renewal Page 3 of 19

this application?

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



The following definitions are provided to assist you in answering questions 35 through 37.

"Ability to practice medicine" - This term includes:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and 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 The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

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

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

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

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

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

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

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

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

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

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

IMPORTANT

Since 1999, Board fees have been used to create and maintain the Vermont Practitioners Health Program, a confidential program for the identification, treatment and rehabilitation of practitioners, including physician assistants, affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line).

Part IV - Statutory Profile Questions

The following questions are required by Vermont law, 26 VSA § 1368, to update and maintain a data

	ot process your applicat riminal Convictions [See		Check here if none	
·	Please provide a descrip or parking tickets) of wh copies of documentat	ich you have been con	nies and misdemeanors; this i victed within the past 10 year	ncludes DUI but not speedii s Please provide comple
	(Conviction Date)	(Court)	(City/State)	(Crime)
39. N	olo Contendere/Matters C	ontinued [See 26 VS/	A § 1368(a)(2)]	here if none
	Please provide a descri	otion of all charges to v	vhich you pleaded "nolo conte	endere" ("I will not contest i
	or where sufficient facts	of guilt were found an	d the matter was continued volete copies of documentate	vithout a finding by a court
	or where sufficient facts	of guilt were found an	d the matter was continued v	vithout a finding by a court
	or where sufficient facts competent jurisdiction.	of guilt were found an Please provide comp	d the matter was continued working the decimentary	vithout a finding by a court ion for each matter.
	or where sufficient facts competent jurisdiction. (Conviction Date)	of guilt were found an Please provide comp (Court)	d the matter was continued worker copies of documentate copies of documentate (City/State)	vithout a finding by a court ion for each matter. (Charge)
0. V	(Conviction Date)	of guilt were found an Please provide comp (Court) (Court) (Court)	d the matter was continued wollete copies of documental (City/State) (City/State) (City/State)	vithout a finding by a court ion for each matter. (Charge) (Charge)

Vermont Department of Health - Board of Medical Practice - 2008-2010 Physician Assistant Certification Renewal Page 5 of 19

(Final Disposition - Summary)

(Date)

	(Date)		(Fi	nal Disposition	- Summar	y)	
Lic	censing or Cert Substitute Check here	ification Authority is if none	Matters in O	ther States [Se	ee 26 VSA	§ 1368(a)(4)]
-	states, the fin	dings, conclusions	s, and orders	of such author	ities, and fi	nal dispositi	on authorities of othe on of such matters b umentation for eac
ite d	of Final Disposi	tion) (Licensin	g or Certifica	ition Authority)	(Court)	(City/State)	(Nature of Charge)
ite d	of Final Disposi	tion) (Licensin	g or Certifica	ition Authority)	(Court)	(City/State)	(Nature of Charge)
Re	estriction of Hos	spital Privileges [S	See 26 VSA	§ 1368(a)(5)]	Xo	heck here if	none
	Revocation/Ir	voluntary Restrict	ions				
	were related t	e a description of o competence or o	any revocat character and	ion or involunta d were issued b	iry restrictions the second in	ital's govern	ospital privileges the
	official of the h	nospital after proce plete copies of de	dural due pro	ocess (opportui	nity for hea	ring) was aff	orded to you. Pleas
	official of the h	nospital after proce	dural due pro	ocess (opportui	nity for hea atter.		orded to you. Pleas
	official of the h	nospital after proce plete copies of de	edural due pro ocumentation	ocess (opporture) on for each ma	nity for hea atter. estriction)	(Reason fo	
	(Date)	nospital after proce plete copies of do (Hospital)	edural due pro ocumentation (State)	Ocess (opportune on for each material of Records) (Nature of Records)	nity for hea atter. estriction)	(Reason fo	or Restriction)
	(Date) B. Other Please provide restriction of p	(Hospital) (Hospital) (Restrictions e a description of a rivileges at a hospital	(State) (State) Check heall resignation ital taken in li	(Nature of Receiver if none as from, or noneur of, or in setti	estriction) estriction) renewal of ement of, a	(Reason fo	or Restriction)
	(Date) B. Other Please provide restriction of pto competence	(Hospital) (Hospital) (Restrictions e a description of a rivileges at a hospital	(State) (State) (Check heall resignation ital taken in linat hospital.	(Nature of Receiver if none as from, or noneur of, or in setti	estriction) estriction) renewal of ement of, a	(Reason fo	or Restriction) or Restriction) of Restriction) of membership or the
	(Date) B. Other Please provide restriction of p to competence each matter.	(Hospital) (Hospital) (Hospital) Restrictions e a description of a rivileges at a hospite or character in the	(State) (State) (Check heall resignation ital taken in linat hospital.	(Nature of Receiver if none eu of, or in setti	nity for head atter. estriction) renewal of ement of, a e complete	(Reason for (Reason for Reason fo	or Restriction) or Restriction) of Restriction) of membership or the

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

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

Please complete the attached Form A and provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past 10 years (10 years from payment date) in which a payment was awarded to a

	complaining p to include fin	arty if not liste al dispositio	ed below. Ple n and, if pos	ease provide comp ssible, a copy of th	lete copies of ne complaint f	documentation, or each matter.
	□ Judgment	□ Arbitratio	on			
	(Date)	(Court)	(State)	(Nature of Case)	(Amount Ass	essed Against You)
	☐ Judgment	☐ Arbitration	νn			
	(Date)	(Court)	(State)	(Nature of Case)	(Amount Ass	essed Against You)
B.	Settlements	Check he	ere if none			
	within the pas complaining p	t 10 years (10 arty if not liste	years from placed below. Ple	ments of medical m payment date) in wh ase provide comp ssible, a copy of th	nich a payment lete copies of	was awarded to a documentation.
	(Date)	(Court)	(State)	(A	mount of Settle	ement Against You)
	(Date)	(Court)	(State)	(A	mount of Settle	ement Against You)
	Practice [See 26 nth and year did	,	/\ ·•	hysician Assistant?	_01/2005	4
you are gr	anting permissio	n to have this	information	?)] Note: Answering posted on the web. pintments, these que	(This form follo	ws the statutory
A.	Appointments					
	faculties			ppointments to med Burlington リー ure of Appointment		
	(School) (Ci	ty) (S	State) (Nat	ure of Appointment) From (ye	ar) To (year)
	(School) (Ci	ty) (S	State) (Nat	ure of Appointment) From (yea	ar) To (year)
В.	Teaching					
\{	education with	in the past 10	years.	r responsibility for t		
<u>Vario</u> (School	ol/Institution)	ont Burling (City)	(State)	ていいから、Midire Of Teachin	ng) Fron	0405- Prcい) n (year) To (year)

	Note: Answering #46 is of posted on the web. Plea literature within the past	optional. By answering, you are granting permis se provide information regarding your publication of years.	sion to have this information ons in peer-reviewed medical
	N A	(Z) (1)	
	(Title)	(Publication)	(Year)
	(Title)	(Publication)	(Year)
47.	Activities [See 26 VSA §	1368(a)(14)]	, ,
	Note: Answering #47 is or posted on the web. Plea activities and awards.	ptional. By answering, you are granting permis se provide information regarding your professio	sion to have this information and or community service
	NIA		
		(Activities or Awards)	
48.]	Practice Setting [See 26 VS What is the location of yo 	A § 1368(a)(15)] our primary practice setting?	
	Town/City, State		
49.]	Translating Services [See 26	5 VSA § 1368(a)(16)]	
	Please identify any transl Are any translating service	ating services available at your primary practice es available at your primary practice location?	e location. ⊠Yes □ No
	If yes, please describe th	e translating services available:	
	in Victually any la		2 003(6/187
50. <u>1</u>	Medicaid/New Patients [See	26 VSA § 1368(a)(17)]	
	A. <u>Medicaid particip</u> Do you participat	<u>ation</u> e in the Medicaid program? ️️Yes □ No)
	B. New Medicaid Pa		
	Are you currently	accepting new Medicaid patients? Yes □	l No

46.

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

Part V

I hereby affirm that the inf	ormation provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.
Date: 1/13/57	Applicant's Signature

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

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

Regarding Child Support

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

impos	se an ui	nreasonable hardship. (15 V.S.A. § 795)
1.	You	must check one of the two statements below regarding child support regardless whether or not you have children: I hereby certify that, as of the date of this appication: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.
	_	or
		I hereby certify that I am <u>NOT</u> in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unasonable hardship. Please forward an "Application for Hardship".
Title 1		Regarding Taxes
perso return	n cerun Is have	3 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the less that he orshe is in good standing with the Department of Taxes."Good standing" means that no taxes are dueand payable and all been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner Φάxes, or authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
2.	You	must check one of the two statements below regarding taxes:
	À	I hereby certify, under the pains and penalties or 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 fineor both).
	· a	hereby certify that LamNOT in good standing with respect to toyon due to the State of Vernanda at 1
	<u>.</u>	I hereby certify that I am <u>NOT</u> in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose annueasonable hardship. Please forward an "Application for Hardship".
T:41 - 0	4 5 4 5 7	Regarding Unemployment Compensation Contributions
(includ	ding a li	8 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade disciness icense to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate
emplo contril all cor the lia payme	ying ur butions itributio bility fo ent plan	ey employing unit unless such employing unit shall first sign a written declaration, wher the pains and penalties of perjury, that the pain is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and one or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment contributions in lieu of contributions due and payable would impose an unreasonable hardship.
3. contril	outions	
	۵	I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a \$10, 000.00 fine or both.)
	0	I hereby certify that I am <u>NOT</u> in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
	Va	Or I hereby certify that 21 V S A & 1379 is not applicable time because I am not applicable time because I
	ye	I hereby certify that 21 V.S.A. § 1378 is not applicable tone because I am not now, nor have I ever been, an employer.
Social	Securit	y # Date of Birth
rie De	partmei	re of your social security number is mandatory, it is solicited by a authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by at of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected and the Office of Chid Support

STATEMENT OF APPLICANT

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

Signature of Applicant Suph Signature of Applicant Date 11/19/2007

PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Inco	mplete applications wil	l be returned. Attach	additional sheets	s as needed.
Name in full	Wong (Last)	Cheung (First)		
		(First)		(Middle)
Mailing Address	FAHC			
un Colo	hester Ave	(Office Name) Smith	421	
Burling		(Street) つちりるし	802-	847-5204
(City/State) / (Zip	Code)	(Telephone	Number)
Vermont License	4: <u>042-00099</u> 68	·		
Hospital(s) where FretcherA//e	you have privileges: n Health Cave	Hospital(s Borce) Location NG TON VT	Specialty 6 YN ONCOLOGY
What arrangement	s have you made for su SUPERVISING 1	pervision when you a	re not available o	or out of town:
	CERTIFICATE	OF SUPERVISING	PHYSICIAN	
the scope of practice,	n accordance with 26 VSA, TAHL, P.A. wh attached to this application, hat a physician assistant is t	ile under my supervision. does not exceed the norm	I further certify the all limits of my prac	t the protocol outlining tice. I further certify that
I further certify that I	have read the statutes and B	1/20	sician assistants. ervising Physician)	
	Co-s	1 -	havi Dte	~/
Note: A PA who prese	cribes controlled drugs must	obtain an ID number from	m DEA. PA's DEA	Number <u>MS 105</u> 7428

Please print. Incomplet	e applications wi	ll be returned. A	ttach additional she	ets as needed.
Name in full(I	clombe	Zulic		A
(1	_ast)	(First)	(Middle)
Mailing Address	letcher Allen	Heolah Con - L	Juma's Health	Core Service
III Colchester A	Wenn YAL FI	Office Nam	e) Partic	
Burlinston Vi (City/State)	0	(Street)	(802) 847	1-1400
(City/State)	(Zi	p Code)	(Telepho	ne Number)
Vermont License #:			÷	÷
Hospital(s) where you h	ave privileges:	Hosp Bulling to	ital(s) Location	Specialty
List all physician's assis	stants names and	addresses you cu	rrently supervise:	
I hereby certify that, in acco of Sephenic Stonly when consulted by the practice, attached to this app VSA, Chapter 31, Section 1' I further certify that I have reconstruction (Date)	rdance with 26 VSA Shu, P.A aforesaid Physician lication, does not ex 741, the use of a phy	c, Chapter 31, I shall conly when the prime is Assistant. I further acced the normal limity sician's assistant has Board rules governing	ery supervising physicities certify that the protocouts of my practice andthe been posted.	for all medical activities an is unavailable and ol outlining the scope of hat in accordance with 26

Please print. Incom	plete applications	will be returned. Attach addition	onal sheets as needed.
Name in full	Soulteneki	Emmenuel (First)	N
	(Last)	(First)	(Middle)
Mailing Address _	Fletcher All	en Heolth Core-Woma's 1	Heolth Conc Service
III Colchis	a Auran 4th	Coffice Name)	
Burlinston	.1/	(Street) D5401 (Zip Code) (Zip Code)	21847-1400
(City/State)	•	(Zip Code)	Telephone Number)
Vermont License #			
Hospital(s) where y	ou have privileges	Bunkelyten UT	tion Specialty OBS94
List all physician's	assistants names a	and addresses you currently supe	ervise:
		ECONDARY SUPERVISING	
only when consulted by practice, attached to thi	the aforesaid Physic s application, does no	/SA, Chapter 31, I shall be legally res P.A. only when the primary supervisin ian's Assistant. I further certify that to the exceed the normal limits of my prace physician's assistant has been posted.	g physician is unavailable and he protocol outlining the scope of
I further certify that I h	ave read the statutes a	and Board rules governing physician a	systems.
10/5/06		Lalt	
(Date)		(Signature of Secondary Supervi	sing Physician)

Please print. Incomplete applications will be re-	turned. Attach additional sheets	as needed.
Name in full <u>Litabakk</u> (Last)		
(Last)	(First)	(Middle)
Mailing Address Loke Chemplein (O	Guneaux Onedosy	
(0	ffice Name)	
(St	treet)	
(City/State) (Zip Code	(Telephone	Number)
Vermont License #:		
Hospital(s) where you have privileges: Dothwhere Medical Conte Capter Control Vir Mont Hospital Porter Hospital List all physician's assistants names and address Grossic Ethobolic	ses you currently supervise:	Specialty Gyn-Oncoding byn-Oncoding byn-Oncoding Gyn-Oncoding
I hereby certify that, in accordance with 26 VSA, Chapter of Secondary P.A. only who only when consulted by the aforesaid Physician's Assista practice, attached to this application, does not exceed the VSA, Chapter 31, Section 1741, the use of a physician's I further certify that I have read the statutes and Board rule (D) 9 0 6	or 31, I shall be legally responsible for a nen the primary supervising physician i ant. I further certify that the protocol o normal limits of my practice andthat i assistant has been posted.	all medical activities s unavailable and utlining the scope of n accordance with 26

Please print. Inco	omplete applicatio	ns will be returne	ed. Attach additio	n al shects	as needed.
Name in full	Visulli (Last)		(First)	-	(Middle)
Mailing Address			<u>ع در جرد در ایم د</u> Name)		
	-	11 Knisht L	e Name)	د	
1.11:44	VIT	/ Conna			12-7001
Willistan (City/Sta	ite)	(Zip Code)	(Tilephane	Number)
Vermont Licens	e#: <u>042 00%)</u>	<i>E</i> £			
Hospital(s) whe	re you have privile	eges:	Hospital(s) Loc	a on	Specialty
List all physicin	an's ussistants nan	nes and addresses	you currently su	ox Visc.	
	ERTIFICATE (
only when contain		was not exceed the n	ormal limits of my pr	ra ice and th	or all medical activities in is unovaliable and of outlining the scope of at in secondance with 26
I further certify (hat I have read the ma		s governing physician	$e \setminus \Omega$	UL

Please print. Inc	complete applicati	ons will be returned. A	ttach additional sheet	s as needed.
Name in full	Cherland	Dick		
	(Last)	(Firs	t) ·	(Middle)
Mailing Address	·Ve	rmunt Uro syme	cology	
	71 1	Knight Lone,	suite 10	
Uilliste (City/Sta		(Street) 05497	E(V2) 8	12-7001
(City/Sta	te)	(Zip Code)	(Telephone	: Number)
Vermont License	e#: 042 00,000	<i>6</i>)		
Hospital(s) when	re you have privil	eges: Hosp	oital(s) Location	Specialty
List all physicia	n's assistants nam	es and addresses you co	urrently supervise:	
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(Date)		(Signature of Seco	indary Supervising Physic	ian

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Name in full					
	(Last)		(First)		(Middle)
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(City/Ctata)	- PONJOTO	<u>- 1 V 7 </u>	05401	728	0202
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Vermont License #	042-007	412			
Hospital(s) where :	you have privileg		Hospital(s)	Location	Specialty 05 6m
List all physician's	assistants names	and addresses	you currently	supervise:	
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Mailing Address _	CD 120	(Office Name)	SYN Core Inc
36 Colcher	er Ave	(Office Name)	
Burlingto	in Vt	(Street) 55401 80 (Zip Code) (2 650 0505
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Mailing Address		Champlein UB/ Con	
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ESSCH	Junctia UT	(Street) US47 L (Zip Code)	679-1802
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Mailing Address	Moite	(Middle)
	Office Name) Col(Luster Auc (Street)	
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Mailing Address Col(Colfice Name)	(Last)	(First) (Middle)
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Vermont License #: 42 - 6010441 Hospital(s) where you have privileges: Hospital(s) Location Specialty Act Bullington VT OBIggo List all physician's assistants names and addresses you currently supervise: CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities only when consulted by the aforesaid Physician's Assistant. I further certify that the rotocol outlining the scope of VSA, Chapter 31, Section 1741, the use of a physician's assistant has been posted. I further certify that I have read the statutes and Board rules governing physician assistants.	- Britista IT	3545 (Street) 42-73354
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	(Last)	(F	irst)	································(Middle)
Mailing Address	Fletcher A	llen Heclah Con	- Women's He	olth Con	Service
III Colchus	or Design Us	(Office N	ame)		
Briefin do	\ \	(Street)	laa	9.1.	
(City/State)	(Street) DS401 (Zip Code)	(202)	1841-140	٥, , , , , , , , , , , , , , , , , , ,
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Hospital(s) where	you have privileg	es: H BM/m, H	ospital(s) Location	on :	Specialty
List all physician's	s assistants names	and addresses you	currently superv	ise:	
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	1 Christine (First)	
Mailing Address Fletch	er Allen Heolah Con - Warm	us Health Conc Service
III Colchater Avenu	(Office Name) (Street) (Sip Code)	ovillian
Burlinston, VT	(Street)	(802) 847-1400
(City/State)	(Zip Code)	(Telephone Number)
Vermont License #: <u>V42-0</u>	009674	
Hospital(s) where you have pr	rivileges: Hospital(s)	Location Specialty UT Oscar
List all physician's assistants	names and addresses you currentl	y supervise:
CERTIFICATI	E OF SECONDARY SUPERVI	SING PHYSICIAN
only when consulted by the aforesa practice, attached to this application VSA, Chapter 31, Section 1741, the	, P.A. only when the primary sur id Physician's Assistant. I further certif	
10/3/06 (Date)	(Signature of Secondary S	

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Name in full	Cassin		Peter		
	(Last)		(First)		(Middle)
Mailing Address	Fletcher	Allan Health C	on - Wama	n's Heolth	Soil Service
III Colchafer	Aucnus,	the Elas AC	e Name) C- Mein ?	avillian	
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Name in full	Bromsto	<u>ک</u> (F	hh	
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Mailing Address _	Fletcher	Allen Health Con	- Womer's Health	Conc Service
III Colchus	er Auenin	4th Flat NCC	ame)	
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Hospital(s) where you	ou have privile	eges: <u>Bn1</u>	Hospital(s) I	Location	Specialty PACY 17
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Hospital(s) where you have pri Fletcher Allen 14ea	ivileges: Hospital(s) Location Per Mily fon, VI	on Specialty/ OTSGYN/MFW
List all physician's assistants n	names and addresses you currently supervisions and addresses you currently supervisions.	rise:
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Mailing Address	letcher Allan Hea	olah Con - War	nais Heolth C	on Service
111 Colchester A	wenus 4th Floor	(Office Name)	Parillian	
Burlinston, VT (City/State)	050	(Street)	(802) 847-	1400
(City/State)	(Zip C	ode)	(Telephone	Number)
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Hospital(s) where you ha	ave privileges:	Hospital(Bafry)	s) Location	Specialty 03540
List all physician's assis	tants names and add	lresses you curren	atly supervise:	
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I hereby certify that, in accor	dance with 26 VSA, Ch	napter 31, I shall be le	gally responsible fo	r all medical activities
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Name in full	Yours,	Roser		C
	(Last)		(First)	(Middle)
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Burlinston	1/4	(Coffice ACC- (Street) DS401 (Zip Code)	(803	2 847-1400
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Name in full Wester (Last)			
(Last)	(First) .	(Middle)
Mailing Address Fletch	er Allen Medlyh Con - L	Jumais Health (
III Colchester Avenue	44 Flage (Office Name	in Pavillian	
Rush he st	(Street) 0 5 4 0 1 (Zip Code)	land are	
(City(State)	<u> </u>	(8031.84)	-1400
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Vermont License #: 043-	1000 9000		
Hospital(s) where you have pri	ivileges: Hosp	ital(s) Location	Specialty (A)
List all physician's assistants r	names and addresses you cu	rrently supervise:	
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The University of Vermont

DIVISION OF GYNECOLOGIC ONCOLOGY
AMBULATORY CARE CENTER
111 COLCHESTER AVENUE
MAIN PAVILION, LEVEL 4
BURLINGTON, VT 05401
PH: (802) 847-5110; FAX: (802) 847-0496



Board of Medical Practice Vermont Department of Health PO Box 70 Burlington, VT 05402-9990

November 19, 2007

To Whom It May Concern:

Please allow this letter to serve as verification that Stephanie Stahl, P.A.-C has been employed full time as a physician assistant with our practice since February 14, 2005. She works as a physician assistant with our inpatient gynecology and gynecologic oncology service, and also sees patients in our ambulatory care clinic for routine gynecologic care.

Please feel free to contact me with any questions.

Cheung Wong, MD

Director, Division of Gynecologic Oncology

Associate Director, Residency Program in OB/GYN

University of Vermont / Fletcher Allen Health Care

802 847 3919 (phone)

802 847 0496 (fax)

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JAN 15 2008

Vermont Board of Medical Practice

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Champlain OB/Gyn

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

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STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

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STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

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WOMEN'S HEALTH CARE SERVICE

In alliance with
The University of Vermont



State of Vermont - Board of Medical Practice

January 18, 2008

To Whom It May Concern:

The enclosed information goes with the rest of Stephanie Stahl's packet that was sent on January 8^{th} , 2008.

Sincerely,

Earline S. Whitcomb Financial Associate

FAHC - Women's Health Care Service

ine & Whiteomb

802-847-7785

PHYSICIAN ASSISTANT SCOPE OF PRACTICE

WOMEN'S HEALTH CARE SERVICES FLETCHER ALLEN HEALTH CARE 111 COLCHESTER AVENUE BURLINGTON, VT 05401

a) NARRATIVE

Fletcher Allen Health Care, Women's Health Care Services is composed of a team of professionals who provide the full scope of OB/GYN services. Physicians certified nurse midwives, nurse practioners and now a physician assistant work in collaborative arrangement. The physician assistant will provide GYN and OB care to our patient population, as do our existing providers. Resident physicians and students rotate through the Women's Health Care Services during their training.

Physician Assistants practice under the supervision of attending OB/GYN physicians. The primary role of the PA is to provide ongoing care for female patients as determined by the PA's training and experience and by the services provided by the supervising physicians. In addition, PA's are involved in both didactic and clinical training of students.

b) SUPERVISION

Supervision of the PA is provided by the primary supervising physicians or one of the secondary supervising physicians when the primary supervising physicians are not available. One of the primary or secondary supervising physicians is available 24 hours a day, 7 days a week. Supervision may include the following mechanisms:

- 1. direct supervision by an attending physician
- 2. consultation with an attending physician in person or by phone
- 3. retrospective chart review
- 4. partricipation in Women's Health Services quality assurance meetings.

c) SITES OF PRACTICE

Fletcher Allen Health Care, Women's Health Care Services:

MCHV Campus, 111 Colchester Avenue, Burlington, VT

UHC Campus, 1 South Prospect Street, Burlington, VT

UHC at Blair Park, Williston, VT

d) TASKS

The following list is intended to express a sense of involvement in medical care provision and is not intended to be all inclusive or limiting, except as specifically excluded by the Board of Medical Practice, health care facility, or law. At no time will the physician assistant function in a capacity that exceeds the normal scope of practice of the supervision physicians. The supervising physician may delegate any and all other tasks that by reason of training and experience, the PA can be expected to perform.

- 1. elicit patient histories
- 2. perform physican examinations
- 3. order laboratory exams, radiographic imaging and other diagnostic testing
- 4. write nursing and other therapeutic orders to be carried out in accordance with hospital policy
- 5. interpret diagnostic and screening studies
- 6. provide telephone advice
- 7. provide education and counseling of patients and arrange for follow-up care and referrals
- 8. insertion of IUDs
- 9. perform routine gynecologic and obstetric tests, including, but not limited to Pap smears, endometrial biopsies, vulvar biopsies
- 10. insert IV ines, catheters, obtain venous and arterial blood samples
- 11. administer or dispense medication in accordance with hospital policy
- 12. assist in gynecologic surgeries
- 13. initiate resuscitative measures in accordance with ACLS standards and hospital policy
- 14. write prescriptions for medications, incuding coltrolled drugs and devices in accordance with Vermont law and DEA regulations

e) PRESCRIPTIVE PRACTICE

The PA named in this document is authorized to prescribe medications, including controlled drugs, in accordance with this scope of practice as approved by the Vermont Board of Medical Practice. The PA's DEA number is: MS 1057428

Stephanie State	1/30/08	
Signature of Physician Assistant	Date	
Signature of Supervising Physician	Date	

The University of Vermont

DIVISION OF GYNECOLOGIC ONCOLOGY
AMBULATORY CARE CENTER
111 COLCHESTER AVENUE
MAIN PAVILION, LEVEL 4
BURLINGTON, VT 05401
PH: (802) 847-5110; FAX: (802) 847-0496



Board of Medical Practice Vermont Department of Health PO Box 70 Burlington, VT 05402-9990

November 19, 2007

To Whom It May Concern:

Please allow this letter to serve as verification that Stephanie Stahl, P.A.-C has been employed full time as a physician assistant with our practice since February 14, 2005. She works as a physician assistant with our inpatient gynecology and gynecologic oncology service, and also sees patients in our ambulatory care clinic for routine gynecologic care.

Please feel free to contact me with any questions.

Cheung Wong, MD

Sincerely

Director, Division of Gynecologic Oncology

Associate Director, Residency Program in OB/GYN

University of Vermont / Fletcher Allen Health Care

802 847 3919 (phone) 802 847 0496 (fax)

NCCPA

National Commission on Certification of Physician Assistants

Stephanie Beth Stahl

has completed all requirements to achieve
NECPA vertification.

(1798-81) **Nonces** (1916-60) † Contraction (1946-1973) (7900)

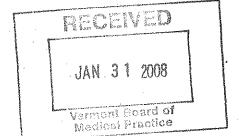




Stephanie Beth Stahl PA FAHC-Womens Health Care Services 1 South Prospect Street BURLINGTON, VT 05401

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

[phone] 802-657-4220 [toll free] 800-745-7371 802-657-4227 Agency of Human Services



Date: January 10, 2008

Dear Physician Assistant:

Your 2008 Physician Assistant certification renewal application has been received by this office and cannot be processed until the following information is received.

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		\$50 renewal fee								4
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		Item 12			Item 32					Item 48
		item 13	Part III						ō	Item 49
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		Item 15			Item 34					Item 50B
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Supervising Phys	ician	ı Forms								

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

JAN 19 2007

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23 Mansfre	id Ave	(Office Name)		
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(City/State)	(Zip C	ode)	(Telephone N	lumber)
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***************************************	Burling	(Office Name)	•	
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RECEIVED 2002 DEC -7 2006 Vermont Board of Medical Practice

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

Please print. Incom	plete applications will be	returned. Attach additiona	sheets as needed.
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STATE OF VERMONT BOARD OF MEDICAL PRACTICE

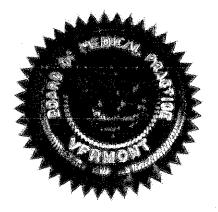
PROFESSIONAL CERTIFICATE

I hereby certify that the following named person is fully qualified to practice as a Physician Assistant in the State of Vermont:

Stephanie Stahl, PAC

P.A. Certification Number: 055-0030719

Valid only while working under the supervision of Cheung Wong MD, Kimberly Blake MD, Elizabeth Bonney MD, Robert Hayward MD, Elisabeth Wegner MD, Roger Young MD, Eleanor Capeless MD, Cathleen Harris MD, David Jones MD, Marjorie Meyer MD, Mark Phillippe MD, John Brumsted MD, Peter Casson MD, Christine Murray MD, Daniel Riddick MD, Julie LaCombe MD, Emmanuel Soultenakes MD, Famal Eltabbakh MD, Anne Viselli MD, Diane Charland MD, Patrick Clifford MD, Dale Lacroix MD, George Till MD, John Gallagher MD, Jill Jertson MD, Amy Thibault MD, Julia Brock MD, Jennie Lowell MD, and Julia Johnson MD, at the FAHC Women's Health Care Center, 1 South Prospect Street, Burlington, VT.



IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the

VERMONT BOARD OF MEDICAL PRACTICE

at Burlington, in the county of Chittenden, State of Vermont, this 17th day of November, A.D. 2006

Administrative Assistant

250KA

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

Please print. Incom	plete applications wi	ill be returned. Atta	ch additional she	ets as needed.
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Vermont Board of Medical Practice

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Name in full Bonney (Last)	Elizobeth	A	
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Mailing Address Fletches	Alle Health Car W.	Wall C	on Service
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Burlinston VT (City/State)	(Street) D5401	(802) 847-	1400
(City/State)	(Zip Code)	(Telephone	Number)
Vermont License #: 042-00			
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Hospital(s) where you have privileges: Hospital(s) Location Specialty				
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(City/State)	1	05901		0071 841-14	00
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Name in full Murroy(Last)	Ch. (F	listine lirst)	(Middle)
Mailing Address Fletches	Alle Medal Car	- Winners Harlie C	. S
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DUPLICATION VI	03401	(8021 841-	1400
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STATE OF VERMONT BOARD OF MEDICAL PRACTICE

PROFESSIONAL CERTIFICATE

I hereby certify that the following named person is fully qualified to practice as a Physician Assistant in the State of Vermont:

Stephanie Stahl, PAC

P.A. Certification Number: 055-0030719

Valid only while working under the supervision of Cheung Wong MD, Kimberly Blake MD, and Julia Johnson MD, at the FAHC Women's Health Care Center, 1 South Prospect Street, Burlington, VT.



IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the

VERMONT BOARD OF MEDICAL PRACTICE

at Burlington, in the county of Chittenden, State of Vermont, this 26th day of October, A.D. 2006

Administrative Assistant

2019

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET

BURLINGTON, VT 05401 (802) 657-4220



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

2006 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION

PARTI

Certificate # 055-0030719
1. Name: Stephanie Beth Stahl PA
2. Other Name(s), if any, under which you were certified or licensed in Vermont and elsewhere:
3. Home Address:
4. Work Address: Women's Health Care Service - Ambulaby Care Center - Main Pavilling Level 4 III Calchester Avenue City, State, Zip Code: Burlington, VT 05401 - 3450
Please check your preferred mailing address: Home Work (This address will be public and listed on the Board's website)
5. Email Address
6. Daytime Telephone Number: Area Code: (802)
7. Date of Birth: Month:
8. Place of Birth
9. Certification Examination Taken – (Check box and enter date of examination):
$A \left(\frac{69/12/03}{} \right)$ NCCPA
(/) State Examination-Identify state:
□ (//) Other Examination specify:
10. Basis for Vermont Certification – (Check box):
□ Apprenticeship Trained ✓ University Trained
11. Do you have hospital privileges in Vermont? ☑(Yes·□ No Hospital Name(s) and Location(s):

Fletcher Allen Mealth Care, Burlington VT 05900
12. In what year did you start working as a physician assistant in Vermont? _ ৩০০৮
13. Did you practice in Vermont during the past 12 months? ☐ Yes ☐ No
14. Other states where you now hold an active certification or license to practice:
15. States where you previously were certified or licensed to practice:
16. Specialty: Women's Health, Gyncology DEA Number: MS 1057428
17. Name and office address of current EMPLOYER:
Name Address
Fletcher Allen Meolth Core III Colchator Avenue Burlingen UT U5401
18. Please list (use additional sheet if necessary) name(s) and address(es) of physicians who currently serve as your PRIMARY and SECONDARY SUPERVISING PHYSICIAN(S).
Primary Supervising Physician(s):
Name Cheuns Wan, MO FAHC- Ambulotory Care Center, Moin Pavillian Level 4
111 Colchester Auchus, Burlayton VT 05401-3456
Secondary Supervising Physician(s):
Julia Johnson, MD FAHR- Ambulatory Care Center Main Pavillian Level 4 110 Colchester Aurnue Burlington UT 05401-3451
110 Colchester Avenue Burlington VT 05401 - 3451
19. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current scope of practice for your practice setting, paying attention to any additions or deletions in duties and procedures. Please review, date and sign your scope of practice and have your PRIMARY SUPERVISING PHYSICIAN sign it as well. Attach a copy of your signed scope of practice to this application.
a. Has there been a change in your scope of practice which has not been reviewed by the Board? Yes D No Sec Sure of Processes Addition of Tup Insurting and Contact with Irrespond
20. Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a Physician Assistant within the past twelve months. See See See Land Littles
21. Continuing Medical Education (CME) requirements:
a. NCCPA certified Physician Assistant: Attach proof of current NCCPA certification; this will serve as

Vermont Department of Health – Board of Medical Practice – 2006-2008 Physician Assistant Certification Renewal Page 2 of 19

adequate proof of CME completion.

- b. For all others, an explanation of requirements and a CME Record form must be completed.
- 22. Primary Supervising Physician and Second Supervisory Physician forms are provided. They must be completed and returned with this application.

PARTII

- "Yes" answers to Questions 23 46 require an explanation on Form A.
- 23. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?
- 24. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?

 □ yes ∀ no
- 25. Have you ever voluntarily suspended, surrendered or resigned a certificate to practice medicine or any other healing art in lieu of disciplinary action?
 - □ yes ★no
- 26. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
 - □ yes '⊊(no
- 27. Have you ever been denied the privilege of taking an examination before any state medical examining board?
 - □ yes 📜 no
- 28. Have you ever discontinued your education, training, or practice for a period of more than three months for reasons other than a family need?
 - □ yes '≾no
- 29. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
 - □ yes 'ছ(no
- 30. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?
 - □ yes ★ no
- 31. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
 - □ yes ⊁ no
- 32. Are you presently or have you ever been a defendant in a criminal proceeding?
 - □ yes 😾 no

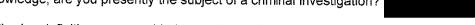
PART III

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

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

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

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



The following definitions are provided to assist you in answering questions 35 through 37.

"Ability to practice medicine" - This term includes:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and 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 The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

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

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

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

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

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

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

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

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

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

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

IMPORTANT

Since 1999, Board fees have been used to create and maintain the Vermont Practitioners Health Program, a confidential program for the identification, treatment and rehabilitation of practitioners, including physician assistants, affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line).

Part IV - Statutory Profile Questions

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

dod	ase include photocopies cuments if your answers nnot process your applic	to questions 38 throu	nsing authority decisions igh 43 have changed sinc	, and any other relevant e your last application. We
38.	Criminal Convictions [Se	e 26 VSA § 1368(a)(1)]	Check here if none	
	or parking tickets) of v	ription of all crimes (felo which you have been co ation for each matter.	onies and misdemeanors; the nvicted within the past 10 years.	is includes DUI but not speeding ears Please provide complete
	(Conviction Date)	(Court)	(City/State)	(Crime)
39.	Nolo Contendere/Matters	Continued [See 26 VS	6A § 1368(a)(2)] <mark>读</mark> Che	ck here if none
	or where sufficient fac	its of guilt were found a	which you pleaded "nolo co nd the matter was continued plete copies of document	ntendere" ("I will not contest it") d without a finding by a court of tation for each matter.
	(Conviction Date)	(Court)	(City/State)	(Charge)
	(Conviction Date)	(Court)	(City/State)	(Charge)
	(Conviction Date)	(Court)	(City/State)	(Charge)
10.	Vermont Board of Medica Please provide a desc Board of Medical Prac appealed.	cription of all formal cha	rges served, findings, conc	Check here if none lusions, and orders of the such matters by the courts, if
	(Date)	(Fina	al Disposition - Summary)	
	(Date)	(Fina	al Disposition - Summary)	
	(Date)	(Fina	al Disposition - Summary)	

Vermont Department of Health - Board of Medical Practice - 2006-2008 Physician Assistant Certification Renewal Page 5 of 19

91. LI	⊘ Che	eck here if no	one		iner States (Se			,,	
	states	, the findings urts, if appea	, conclusions	, and orders	arges served by of such author se provide co	ities, and	final dispositi	on of such m	natters by
(Date	of Final	Disposition)	(Licensin	g or Certifica	tion Authority)	(Court)	(City/State)	(Nature of C	Charge)
(Date	of Final	Disposition)	(Licensin	g or Certifica	tion Authority)	(Court)	(City/State)	(Nature of C	Charge)
42. Re	estriction	n of Hospital	Privileges [S	See 26 VSA {	§ 1368(a)(5)]	×	Check here if	none	·
	Revoc	ation/Involu	ntary Restricti	ions					
	were r	elated to cor of the hospi	npetence or c al after proce	character and dural due pro	on or involunta d were issued b ocess (opportu on for each ma	y the hos nity for hea	pital's govern	ing body or a	anv other
	(Date)		(Hospital)	(State)	(Nature of Re	estriction)	(Reason f	or Restriction	n)
	(Date)	•	(Hospital)	(State)	(Nature of Re	estriction)	(Reason f	or Restriction	n)
	В.	Other Res	trictions	Check he	re if none				
	restrict	ion of privile petence or c	ges at a hospi	ital taken in li	is from, or non- eu of, or in settl Please provi d	ement of,	a pending dis	sciplinary cas	e related
	(Date)			(Ho	spital)		(State)	***************************************	
		e of Action) on for Action)	□ In lieu	(Action) □ In settle	ement		· · · · · · · · · · · · · · · · · · ·	•
	(
43. M€	edical Ma	alpractice Co	ourt Judgmen	ts/Settlemer	ts [See 26 VS	A § 1368(a)(6A)]		
	A.	Judgments	_ K Chec	k here if non	e				
		court judgr the past 10 complainin	nents against years (10 ye g party if not l	you and all ears from pay listed below.	A and provide medical malpra ment date) in version of the provide possible, a co	ctice arbi vhich a pa le comple	tration award ayment was a ete copies o	s against you awarded to a f documenta	u within ation.

	☐ Judgment	☐ Arbitration	n		· ·
	(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Against You)
	☐ Judgment	□ Arbitration	1		·
	(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Against You)
В.	Settlements	Check her	e if none		
	within the past complaining page	: 10 years (10 ₎ arty if not listed	years from I below. Ple	payment date) in whease provide comp	alpractice claims against you ich a payment was awarded to a lete copies of documentation, e complaint for each matter.
	(Date)	(Court)	(State)	(A	mount of Settlement Against You)
	(Date)	(Court)	(State)	(A	mount of Settlement Against You)
	Practice [See 26 nth and year did	-		^P hysician Assistant?	01/2004
What mon	nth and year did nents/Teaching ranting permissio	you start pract [See 26 VSA § n to have this i	cicing as a F 1368(a)(1: information	Note: Answering posted on the web.	#48 is optional. By answering, (This form follows the statutory estions may overlap.)
What mon	nth and year did nents/Teaching ranting permissio	you start pract [See 26 VSA § n to have this i	cicing as a F 1368(a)(1: information	Note: Answering posted on the web.	#48 is optional. By answering,
What moderate Management Manageme	nth and year did nents/Teaching ranting permissio Since most appoin Appointments Please provide faculties.	you start pract [See 26 VSA § n to have this intments are tea	1368(a)(1: 1368(a)(1: information aching appo	2)] Note: Answering posted on the web. ointments, these que	#48 is optional. By answering,
What mo Appointm you are gr wording. S	nth and year did nents/Teaching ranting permissio Since most appoin Appointments Please provide faculties.	you start pract [See 26 VSA § n to have this intments are tead	1368(a)(1: information aching appearance bout your a tate) (Na	2)] Note: Answering posted on the web. ointments, these que	#48 is optional. By answering, (This form follows the statutory estions may overlap.) ical school or professional school Charet Lastructor - 2059 From (year) To (year)
What mon Appointm you are gr wording. S	nth and year did nents/Teaching ranting permissio Since most appoin Appointments Please provide faculties. University (School) (Ci	you start pract [See 26 VSA § n to have this intments are tead	1368(a)(1: information aching appearance bout your a tate) (Na	2)] Note: Answering posted on the web. ointments, these que ppointments to med ture of Appointment	#48 is optional. By answering, (This form follows the statutory estions may overlap.) ical school or professional school Chace Laskueter - 2009 From (year) To (year)
What more	nth and year did nents/Teaching ranting permissio Since most appoin Appointments Please provide faculties. (School) (City (School) (City (City))	you start pract [See 26 VSA § n to have this interests are teach information at ty) (St information re	1368(a)(1: 156(a)(1: 167(a)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	2)] Note: Answering posted on the web. ointments, these que ppointments to med ture of Appointment ture of Appointment	#48 is optional. By answering, (This form follows the statutory estions may overlap.) ical school or professional school Chace Laskueter - 2009 From (year) To (year)

46. <u>Publications</u> [See 26 VSA § 1368(a)(13)]

Note: Answering #49 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 numbers literature within the past 10 years.				
	(Title)	(Publication)	(Year)	
	(Title)	(Publication)	(Year)	
47.	Activities [See 26 VSA	§ 1368(a)(14)]	, ,	
	Note: Answering #50 is posted on the web. Ple activities and awards.	s optional. By answering, you are granting permissio ease provide information regarding your professiona	on to have this information of community service	
		(Activities or Awards)		
48. <u>F</u>	Practice Setting [See 26 V	'SA § 1368(a)(15)]		
	What is the location of Fletcher Allan Health	your primary practice setting? لہ گورد		
49. <u>]</u>	Town/City, State Ourlington, VT Franslating Services [See	26 VSA § 1368(a)(16)]		
_	Please identify any tran	nslating services available at your primary practice lovices available at your primary practice location?	ocation. ☑ Yes □ No	
	4	the translating services available: on 600 humber and Flock a translation	chor in any	
	Petint for oppose	en 600 humber and Flock e transle were With hope, we can also have trap	a status accompany	
50. <u>N</u>	Medicaid/New Patients [Se	ee 26 VSA § 1368(a)(17)]		
	A. <u>Medicaid partic</u> Do you particip	<u>sipation</u> ate in the Medicaid program?		
	B. New Medicaid I	<u>Patients</u> tly accepting new Medicaid patients? '떱Yes □ N	lo	

Part V

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

Date: W 5/2007 Signature

Applicant's Signature

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

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You <u>must</u> answer	questions	1,	2,	and	3,
------------------------	-----------	----	----	-----	----

Regarding Child Support

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

1.	¥9L	I <u>must</u> check 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 thisapplication: (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 dueunder that order.
		I hereby certify that I am <u>NOT</u> in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose aunreasonable hardship. Please forward an "Application for Hardship".
T'11 - 00		Regarding Taxes
returns	certifi have	3 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the less that he or she is in good standing with the Department of Taxes."Good standing" means that no taxes are dueand payable and all been filed the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissionef Taxes, or authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
2.	You	must check one of the two statements below regarding taxes:
	ZI.	I hereby certify, under the pains and penaltis 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 fne or both).
		or
		I hereby certify that I am <u>NOT</u> in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would imposen unreasonable hardship. Please forward an "Application for Hardship".
Title 24 :	6 497	Regarding Unemployment Compensation Contributions 8 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a tradar business
(includir space we employi contribution all contribution the liabil payment employed)	ig a li ith ar ng un tions ibutio lity fo t plan	icense to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate by employing unit unless such employing unit shall first sign a written declaration under the pains and penalties of perjury, that the nit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of due as of the date such declaration is made. Fo the purposes of this section, a person is in good standing with respect to any and one or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment contributions in lieu of contributions due and payable would impose an unreasonable hardship.
3. contribu	tions	
	X	I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a \$10,000.00 fine or both.)
		I hereby certify that I am <u>NOT</u> in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determinethat requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
		I hereby certify that 21 V.S.A. § 1378 is not applicate to me because I am not now, nor have I ever been, an employer.
Social S		
the Depa	rtmei	ure of your social security number is mandatory, it is solicite by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by nt of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected and by the Office of Child Support.

____ Date 11/05/2025

STATEMENT OF APPLICANT

I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false

information or omission of information is unlawful and may jeoprdize my license/certification/registration status.

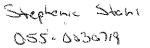
Sterr, PA-C

Signature of Applicant_

PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incor	nplete application	ons will be returned. Attac	ch additional s	neets as needed.	
Name in full	Won	Cheons (First)			
Mailing Address	Warner's P	(Office Name) Her Auchus (Street) (Zip Code)	Gyl Oncolos	4 - 44- Floor ACC	Mein Pourl
	111 Calche	Act Auchue			-
Burl	instea Vi	(Street) - 05401	(402)	847-5110	
(City/State)		(Zip Code)	(Teleph	one Number)	
Vermont License #					
Hospital(s) where y Fletcher Alla 1	ou have priviles	ges: Hospital	(s) Location	Specialty bynecologic Onc	13 60 Eq
What arrangements		for supervision when you some supervision when you some supervision when you some supervision when you supervision			
the scope of practice, a	accordance with 26	5 VSA, Chapter 31, I shall be le P.A. while under my supervision cation, does not exceed the not tant is used, in accordance with	egally responsible on. I further certification	for all medical activities for all medical activities that the protocol outling practice. I further certifications	ning
I further certify that I h	ave read the statute	s and Board rules governing pl	ysician assistants	•	
11/30/07 (Date)			ane /		
(Date)			pervising Physic		
		Co-signature of PA:	the Day	e, pa.c	
Note: A PA who prescr	ibes controlled dru	s must obtain an ID number fi	rom DEA PA's l	DEA Number M.5 to	57411

Please print. Inc	omplete application	ns will be returned. Attac	h additional sheets	s as needed.	
Name in full	Lohne	(First)		V	
	(Last)	(First)	,	(Middle)	
Mailing Address	Fletcho Alla	n Meelth Con- librar	SHCS ACC	4th Flow Mei	· leuleo
	181 Colchot	(Office Name)			
Burlin	uton It	(Street) (5 90 ((Zip Code)	(802) 8º	17-1400	
(City/Stat	te)	(Zip Code)	(Telephone	Number)	
Vermont License	: #:				
Hospital(s) where Fletcher Ale	e you have privileg — Malun Care	es: Hospitale	(s) Location	Specialty Gyneway RE	seed areas. And Andreas.
List all physician	's assistants names ⊃+661 (Wijnd	and addresses you currer	atly supervise:	obex Julyton Wo	,5751
C	ERTIFICATE O	F SECONDARY SUPER	RVISING PHYSI	CIAN	
consulted by the aforto this application, de	resaid Physician Assist	VSA, Chapter 31, I shall be le. A. only when the primary supported ant. I further certify that the primal limits of my practice and that has been posted.	ervising physician is u rotocol outlining the s	mavailable and only v	when hed
I further certify that I	have read the statutes	and Board rules governing phy	4	n) (f)	





PHYSICIAN ASSISTANT SCOPE OF PRACTICE

Women's Health Care Services Fletcher Allen Health Care Ambulatory Care Center 111 Colchester Avenue Burlington, VT 05401

a. Narrative

Women's Health Care Services at Fletcher Allen Health Care is composed of a team of professionals who provide the full scope of OB/GYN services. Physicians, certified nurse midwives, nurse practitioners and now, a physician assistant (PA), work in collaborative arrangement. The PA will provide gynecologic and obstetric care to our patient population, as do our existing providers. Resident physicians and students rotate through the Women's Health Care Services during their training.

Physician assistants practice under the supervision of attending OB/BYN physicians. The primary role of the PA is to provide ongoing care for female patients as determined by the PA's training and experience and by the services provided by the supervising physicians. In addition, PA's are involved in both didactic and clinical training of students.

b. Supervision

Supervision of the PA is provided by the primary supervising physicians or one of the secondary supervising physicians when the primary supervising physicians are not available. One of the primary or secondary supervising physicians is available 24 hours a day, 7 days a week. Supervision may include the following mechanisms:

- 1. Direct supervision by an attending physician.
- 2. Consultation with an attending physician in person or by phone.
- 3. Retrospective chart review.
- 4. Participation in Women's Health Care Services quality assurance meetings.

c. Sites of Practice

Women's Health Care Services, Fletcher Allen Health Care:

Ambulatory Care Center, 111 Colchester Avenue, Burlington, VT Blair Park, Williston, VT

d. Tasks

The following list is intended to express a sense of involvement in medical care provision and is not intended to be all-inclusive or limiting, except as specifically excluded by the Board of

Medical Practice, health care facility, or law. At no time will the PA function in a capacity that exceeds the normal scope of practice of the supervising physicians. The supervising physician may delegate any and all other tasks that by reason of training and experience, the PA can be expected to perform.

- 1. Elicit patient histories.
- 2. Perform physical examinations.
- 3. Order laboratory exams, radiographic imaging and other diagnostic testing.
- 4. Write nursing and other therapeutic orders to be carried out in accordance with hospital policy.
- 5. Interpret diagnostic and screening studies.
- 6. Provide telephone advice.
- 7. Provide education and counseling of patients and arrange for follow-up care and referrals.
- 8. Perform euglycemic clamps.
- 9. Perform routine gynecologic and obstetric tests and procedures including, but not limited to Pap smears, endometrial biopsies, vulvar biopsies, IUD insertion, in-office treatment of genital warts.
- 10. Insert I.V. lines, catheters, obtain venous and arterial blood samples.
- 11. Administer or dispense medication in accordance with hospital policy.
- 12. Assist in gynecologic surgeries.
- 13. Initiate resuscitative measures in accordance with ACLS standards and hospital policy.
- 14. Write prescriptions for medications, including controlled drugs and devices in accordance with Vermont law and DEA regulations.

e. Prescriptive Practice

The PA named in this document is drugs, in accordance with this scope of Practice. The PA's DEA number is:	practice, as approved b	medications, including controlled by the Vermont Board of Medical
Signature of Physician Assistant		11/30/2607 Date
- Clark		11/50/05
Signature of Supervising Physician		Date

世のらなるとろうフィ



In alliance with
The University of Vermont

WOMEN'S HEALTH CARE SERVICE

> Board of Medical Practice Vermont Department of Health PO Box 70 Burlington, VT 05402-9990

To Whom It May Concern:

Please allow this letter to serve as verification that Stephanie Stahl, P.A.-C has been employed full time as a physician assistant with our practice since February 14, 2005. She works as a physician assistant with our inpatient gynecology and gynecologic oncology service, and also sees patients in our ambulatory care clinic for routine gynecologic care.

Please feel free to contact me with any questions.

Sincerely,

Cheung Wong, MD

Director, Gynecologic Oncology

Fletcher Allen Health Care

4th Floor, Main Pavilion ACC

Burlington, VT 05401

(802)847-5110

The National Commission on Certification of Physician Assistants affirms that

Stephanie Beth Stahl

has successfully completed all requirements to achieve or maintain NCCPA certification.

Certificate Number: 1059860 Quity Ratts op

Expiration Date December 31, 2007

resident

This card does not constitute proof of certification. Please contact NCCPA for verification.





STATE OF VERMONT BOARD OF MEDICAL PRACTICE

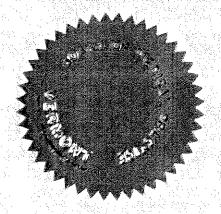
PROFESSIONAL CERTIFICATE

I hereby certify that the following named person is fully qualified to practice as a Physician Assistant in the State of Vermont:

Stephanie Stahl, PAC

P.A. Certification Number: 055-0030719

Valid only while working under the supervision of Cheung Wong MD, and Julia Johnson MD, at the FAHC Women's Health Care Center, 1 South Prospect Street, Burlington, VT.



IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the

VERMONT BOARD OF MEDICAL PRACTICE

at Burlington, in the county of Chittenden, State of Vermont, this 5th day of January, A.D. 2005

Administrative Assistant



Vermont Department of Health Board of Medical Practice

Agency of Human Services

January 5, 2005

Stephanie Stahl PA

RE:

Physician's Assistant Certification 055-0030719

Dear Ms. Stahl:

Congratulations! On January 5, 2005, you were presented and approved for certification as a Physician Assistant in the State of Vermont. Enclosed is your printed certificate. This is to be placed at your place of employment, to be visible for the public.

Physician's Assistant certifications are renewed in January of every even year. You will be sent a renewal form two months prior to the expiration date.

If you have any questions or concerns, please do not hesitate to contact me at (802) 657-4223.

Sincerely,

Tracy Hayes

Administrative Assistant

IT IS YOUR RESPONSIBILITY TO NOTIFY THIS BOARD OF ADDRESS CHANGE OR TERMINATION OF EMPLOYMENT



Vermont Department of Health Board of Medical Practice

Agency of Hun in Services

December 28, 2004

Katherine Silta PA-C®

Dear Cassie:

The application for licentary for Stephanie Stahl, P.A. appears complete, and is enclosed for your review. This PA has previously been licensed in Vermont. You may present the application at the first, regularly scheduled Board meeting.

Should you have any questions or concentrations

e let me know. (802) 657-4223.

Sincerely,

Tracy Hayes Administrative Assistant Board of Medical Practice

Enclosures

Well Center (

PHYSICIAN ASSISTANT SECONDARY CERTFICATION STATUS SHEET

NAME: <u>5</u>	repredie Stabl	
PHONE:		
ADDRESS:		
EMPLOYER:	FAIR DOOL OBIGYIN	
ADDRESS:	1 south Prosped St	
TOO VALORET THEY ATTO AND ARM MADE AND A TOO	Burl vr 05401	
DATE RECEIV	VED: 12/08/04	
<u>X</u>	Application Fee of \$50	
<u>\delta</u>	Completed Application for Certification as a Physician Assistant in Vermont (Signed & dated)	
	Child Support/Tax/Unemployment Form	
1	Employment Contract	
*	Primary Supervisor Physician Application (Signed by PA & Supervisor)	
X	Secon JUNA DONSON Lic #: 040-0008140	
	M.D.: Lic #:	
X AIG	Scope of Practice (signed by PA and Primary Supervisor) A detailed description Of the duties and scope of practice to include authority to prescribe medications. Completed Form A, if applicant answered Ayes≅ in Section III	
<u></u>	Federation Disciplinary C	

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

DEC 28 2004

APPLICATION FOR CERTIFICATION AS A PHYSICIAN'S ASSISTANT IN VERMONT PAGE ONE OF SEVEN

FEE: Enclose a check in the amount of \$100 if initial certification (\$50 if not initial) made payable to the Vermont Board of Medical Practice.

important:

- Please print legibly or type your answers.
- Answer all questions (front and back of each page) completely-it is not adequate to state that the Board already has the information. Use the enclosed Form A to provide explanations to "yes" answers in Section II.
- Incomplete applications will be returned.
- When space provided is insufficient, attach additional sheets.
- All documents must be received within six (6) months or the application becomes stale and new documents must be submitted.
- Make a copy of this form and all attachments for your own records.
- Carefully complete the application as false statements are grounds for unprofessional conduct.
- Thank you for your cooperation.

☐ Vermont Apprenticeship Trained

SECTION I						
Name:	Stahl	Stephanie	Beth			
	(Last)	(First)	(Middle)	(F	ormer)	
Mailing Ad	ldress:					
		Street)				
(City)		(State)		(Zip Code)	(Phone)	
Office Add	dress.					
O III O C F IQ		(Street)				
		•				
(City)		(State)		(Zip Code)	(Phone)	
	14					
Home Ad	dress:	(Street)				
		,				
(City)		(State)		(Zip Code)		
(01.57		(0000)		(—, · · ·)		
Dautima	Telephone Number: (
Dayume	reiepholie (value). (
Onto =5 5	Director & Amento		Day	Year		
Date or c	Birth: Month:		Day	_ 1 ea1		
01	Ph. Ata		Say: C Main	Enmain		
Place of	Birth.		Sex: □ Male	NA LEMBIE		
	r Licensure: University Trained - NC	ODA Evamination				

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE APPLICATION FOR CERTIFICATION AS A PHYSICIAN'S ASSISTANT, PAGE TWO OF SEVEN

NAME FOR CERTIFICATE - NAME CHANGES - OTHER NAMES CERTIFIED/ LICENSED

Name as it should appear on your ce	entification: <u>Stephenie</u>	340M1	•	
lave you ever legally changed your f Yes, enclose a certified copy of the	name?YesNo legal document stating the chang	e.		
Other Name(s), if any, under which y	rou were certified / licensed elsewh	nere:		
	EDUCATION (College Forw	ard)		
University of Illin	01/199(- b	5/1994	B.S Biologi	
(Name and location of Institution)	(From/To-Month/Year)		(Degree)	
Duke United Sity (Name and location of Institution)	(From/To-Month/Year)	120003 PL	nysicie, Α <u>ssic</u> (Degree)	Sent/Mastor of Health Sciences
(Name and location of Institution)	(From/To-Month/Year)		(Degree)	_
	SUPERVISING PHYSICIA	NS		
List name and specialty of super Supervisor's Name		•	isor's Specialty	
Tipostly Fitz serold,	D. 6'	Urge	4 Care	nonan-ira
List name and specialty of secon		dan Grandala	Physician's Specia	
Piece Ansier Do.	n(s) Secon		•	•
and the second second second second	PRACTICE	j	e e	ki aris i gi i i i ya
Have you ever held a Vermont Ter		<u>⊬</u> No If Yes, wh	en:	
Do you have hospital privileges? List all hospitals where you have,	Yes No or previously have had, privileges	- include name, add	dress, and dates:	
NAME	ADDRESS	FROM/TO	SPECIALTY	
				•

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE APPLICATION FOR CERTIFICATION AS A PHYSICIAN'S ASSISTANT, PAGE THREE OF SEVEN

TRAINING

List chronologically residency or other formal medical training programs. Give names, addresses of hospitals, exact dates (month, day, year), and type of training. Include COPIES OF CERTIFICATES.

The significant training affecting your work as a physician's assistant g, courses in such areas as laboratory or x-ray technology, physical therapy, EMT): The significant training affecting your work as a physician's assistant g, courses in such areas as laboratory or x-ray technology, physical therapy, EMT): The significant training affecting your work as a physician's assistant g. Course	ame	Address	From/To	Training
To you hold, or have you ever held, a license/certification in any other state? No if yes, complete section below and send a Verification of Physician's Assistant Licensure or Certification to each state. The section below and send a Verification of Physician's Assistant Licensure or Certification to each state. The complete c	.g., courses	in such areas as laboratory or x-ray techno	logy, physical therapy, EMT):	ea
The section below and send a Verification of Physician's Assistant Licensure or Certification to each state. The Certificate/License Number Date Issued Status (Active or inactive) The your a graduate of a program accredited by the Committee on Allied Health Education and Accreditation (AHEA) or its successor agency? Yes No To you hold a NCCPA Certificate? Yes No If yes, attach a copy. The are your scheduled to begin work in Vermont? Expiration Date: 12/31/2007 Then are your scheduled for certification in Vermont? Yes No Tyes: Under what name Stephenic St		- ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
The your a graduate of a program accredited by the Committee on Allied Health Education and Accreditation (AHEA) or its successor agency? Yes No if yes, attach a copy. CCPA Certificate Number: 1059 860 Expiration Date: 12/31/2007 Then are you scheduled to begin work in Vermont? Yes No Yes No Yes: Under what name Stephanic Yes No Yes: Under what name Yes No Yes No Yes: Under what name Yes No Yes: Under what name Yes No Yes: Under What has been your physical residence (City, State) in the past ten years? Essex Sunction, WY (08) Yes No Yes: Under What	o you hold, o he section be	or have you ever held, a license/certification flow and send a Verification of Physician's flow a Verification of the physician's flow and a Verification of the physician's flow a Verification of the physician of the phys	n in any other state?Yes _ Assistant Licensure or Certificati	No if yes, complete on to each state.
CCPA Certificate Number: 1059860 Expiration Date: 12/31/2007 Then are you scheduled to begin work in Vermont? OV 03/2007 Expiration Date: 12/31/2007 Then are you scheduled to begin work in Vermont? Yes No Year 2009 Vest: Under what name Stephanic Steph	State	Certificate/License Number	Date Issued Status	(Active or inactive)
O you hold a NCCPA Certificate?	√re you a gra (CAHEA) or il	duate of a program accredited by the Comes successor agency? Ves No	mittee on Allied Health Education	n and Accreditation
CCPA Certificate Number: 1059860 Expiration Date: 12/31/2007 Then are you scheduled to begin work in Vermont? OV 03/2007 Eave you previously applied for certification in Vermont? Yes No Year 2009 Very Under what name Stephanic Stephanic Year 2009 Vhat has been your physical residence (City, State) in the past ten years? Essex Sunction, VT (08) The pet Hill, No. 108/1996-08/2008). Chicase, To (1999-1996) Urbane, Thinks (1996-1999) Have you ever discontinued your practice as a physician's assistant or physician's assistant trainee for a peri	-	· · · · · · · · · · · · · · · · · · ·	if yes, attach a copy.	
In the past ten years? It was trained to the past ten years? The p				<u> </u>
What has been your physical residence (City, State) In the past ten years? Essex Sunction, VT (08 Chapet Hill, NC (08/1996-08/2006) Chapet It (1999-1996) Urbane, Illinois (1996-1994) lave you ever discontinued your practice as a physician's assistant or physician's assistant trainee for a period.	When are yo	u scheduled to begin work in Vermont?	BY 03/ 2007	
What has been your physical residence (City, State) In the past ten years? Essex Sunction, VT (08 Chapet Hill, NC (08/1996-08/2006) Chapet It (1999-1996) Urbane, Illinois (1996-1994) lave you ever discontinued your practice as a physician's assistant or physician's assistant trainee for a period.	Have you pro	wiously applied for certification in Vermont	7 Yes No	
Urbane, Illinois (1991-1994) lave you ever discontinued your practice as a physician's assistant or physician's assistant trainee for a peri		•		iundia, VT (08/8
lave you ever discontinued your practice as a physician's assistant or physician's assistant trainee for a peri	Chapel 1	111, NC 608/1991-08/2003)	Chicago, Il (1994-	1996)
lave you ever discontinued your practice as a physician's assistant or physician's assistant trainee for a peri nore than six months?Yes No if yes, explain:	Urbone	Illinois (1991-1994)		
	Have you ev	er discontinued your practice as a physicia	in's assistant or physician's assi in:	stant trainee for a p

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE APPLICATION FOR CERTIFICATION AS A PHYSICIAN'S ASSISTANT, PAGE FOUR OF SEVEN

SECTION II

PROVIDE A PHOTOGRAPH: Attach a photograph taken within the last 60 days (head and shoulders). Proofs not acceptable. Sign the front of the photograph.

PHOTOGRAPH

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE APPLICATION FOR CERTIFICATION - PHYSICIAN'S ASSISTANT, PAGE FIVE OF SEVEN

SECTION III

SECTION III - "Yes" answers to Questions 1 - 24 requires an explanation on the enclosed Form A.

1.	Have you ever applied for and been denied a certification/license to practice as a PA or any healing art?Yes
2.	Have you ever withdrawn an application for a certification/license to practice as a PA or any healing art?YesNo
3.	Have you ever voluntarily surrendered or resigned a certification/license to practice as a PA or any healing art in lieu of disciplinary action? Yes
4.	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 PA association (international, national, state or local)? Yes
5.	To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application?
6.	Have you ever been denied the privilege of taking an examination before any State Medical Examining Board? YesNo
7.	Have you ever discontinued your education, training, or practice for a period of more than three months? YesNo
8.	Have you ever been dismissed or asked to leave a residency training program(s) before completion?Yes/_No
9.	Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked; resigned from a medical staff in fleu of disciplinary action; or resigned from a medical staff after a complaint or peer review action has been initiated against you?
10.	Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?
11.	Have you ever been notified as a responsible party of a confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? YesNo
12.	Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim/complaint/demand for damages)?
13.	Have you ever been turned down for coverage by a malpractice insurance carrier? YesNo
14.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered by any jurisdiction or federal agency at any time?
15.	Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses (Note: DWI - Driving While Intoxicated - is NOT a minor offense)?
16.	To your knowledge, are you the subject of an investigation for a criminal act?

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE APPLICATION FOR CERTIFICATION - PHYSICIAN'S ASSISTANT, PAGE SIX OF SEVEN

SECTION III CONTINUED - "Yes" answers to Questions 17 - 24 requires an explanation on the enclosed Form A. For purposes of Questions 17 - 24, the following phrases or words are defined below:

"Ability to practice medicine" is to be construed to include all of the following:

- The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
- 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
- The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

"Chemical substances" 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 likegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past five (5) years.

"illegal use of controlled substances" means the use of controlled substances obtained illegally as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

- 17. Do you have a medical condition which in any way impairs or limits your ability to practice as a PA with reasonable skill and safety? If "yes," please explain.
- 18. Does your use of chemical substance(s) in any way impair or limit your ability to practice as a PA with reasonable skill and safety? If "yes," please explain.
- 19. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If "yes," please explain.
- 20. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If "yes," please explain.
- 21. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voveurism? If "yes," please explain.
- 22. Are you currently engaged in the illegal use of controlled substances?
- 23. If "yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not filegally using controlled substances? If "yes," please explain.
- 24. Have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranola, or any other psychotic disorder?

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE - PAGE SEVEN OF SEVEN SECTIONIV

STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

Applicant's Statement 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 filled. "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. §

95)	sections described management believes to appear to the contract of the contra
•	You <u>must</u> check one of the two statements below regarding child support regardless whether or not you have children:
<u>*/</u>	I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order. Or
······································	I hereby certify that I am <u>NOT</u> in good standing with respect to child support due as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship". Applicant's Statement Regarding Taxes
nless th	3113 requires that: A professional Scense or other authority to conduct a trade or business may not be issued or renewed e person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or sing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
L	You <u>must</u> check one of the two statements below:
W	I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compilance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both).
or busin services pains ar and all (section, contribu contribu Commit	i hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship". Applicant's Statement Regarding Unemployment Compensation Contributions § 1378 requires that: No agency of the state shall grant, issue or renewal any license or other authority to conduct a trade ess (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the independent of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this a person is in good standing with respect to any end all contributions or payments in lieu of contributions are due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the isolators; or (4) in the case of a flossese, the agency finds that requiring immediate payment of contributions or payments in lieu of unemployment contributions: You must check one of the two statements below regarding unemployment contributions or payments in lieu of unemployment contributions: I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment in the date of this application. (The maximum penalty for perjury is 15 years in prison, a \$10,000.00 fine or both).
	I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in fieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in fieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
2 T	Date of Birth Date of Birth Date of Birth Descript # Descript runnber is mandatory, is existing by secondary granted by 42 U.S.C. § 405 (c)(2)(0), and will be used by the Department of and the Department of Employment and Training, in the administration of fax laws, to identify individuals affected by each laws, and by the Office of Child Support. STATEMENT OF APPLICANT
l certify providi	y that the information stated by me in this application is true and accurate to the best of my knowledge. I understand that my takes information or oriestion of information is unlawful and may jeopardize my license/certification/registration status.
Signat	ure of Applicant Suphran Dtd. Date 34+ 12/26/2004

EMPLOYMENT CONTRACT

1, Stephonic Stehl (Applicant's Name)	, an applicant for
Certification as a Physician's Assistant, am employed by	
Fletcher Allen Health Center - Deportment of Gynecols (Employer's Name)	y/ bynerdusic Oncology
for the period beginning <u>0\/ 03/2005</u> (Month/Day/Year)	
(Month/Day/Year)	
Termination of my contract will cause my Certification to be	pecome null and void.
Dephen Stell	Molostac
Signature of Physician's Assistant	(Date)
Signature of Supervising Physician	12/20/4_ (Date)
Signature of Supervising Physician	(Date)
Print Name of Physician: Chevry Wong	

NOTE: A contract from each separate employer is required.

VERMONT DEPT OF HEALTH BOARD OF MEDICAL PRACTICE 108 CHERRY ST PO BOX 70 BURLINGTON VT 05402-0070 802-657-4220

PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed. Name in full Vermont License Number: 042-0009968 Number of years you have been practicing medicine: 12 Hospital(s) where you have privileges Hospital(s) Location List all physician's assistants names and addresses you currently supervise: What arrangements have you made for supervision when you are not available or out of town: ____ CERTIFICATE OF SUPERVISING PHYSICIAN I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of , P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician's assistant is used, in accordance with 26 VSA. Chapter 31, Section 1741. I further certify that I have read the statutes and Board rules governing physician's assistants. Co-signature of PA: Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number: 105 1057 418 VERMONT DEPT OF HEALTH BOARD OF MEDICAL PRACTICE 108 CHERRY ST PO BOX 70 BURLINGTON VT 05402-0070 802-657-4220

Please print. Incomplete applications will be returned. Attach add	litional sheets as needed.
Name in full OANSON (First)	(Middle)
Mailing Address <u>UHC/FAHC</u> (Office Name)	
1 So Prospec	£ (2)
Baline ton V	T 05401 847-1400
(City/State) / (Zip Code)	(Telephone Number)
Vermont License Number: 8140 Number of years you	have been practicing medicine:
Hospital(s) where you have privileges Hospital(s	Location Specialty
rate Barl	ington UT OB/640
List all physician's assistants names and addresses you current	y supervise:
CERTIFICATE OF SECONDARY S I hereby certify that, in accordance with 26 VSA, Chapter 31, I a Stephane Standard Physician outlining the scope of practice, attached to this application, doe in accordance with 26 VSA, Chapter 31, Section 1741, the use	hall be legally responsible for all medical activities of A. only when the primary supervising physician is i's Assistant. I further certify that the protocol s not exceed the normal limits of my practice and that
I further certify that I have read the statutes and Board rules go	verning physician's assistants.
12/21/04	(Signature of Secondary Supervising Physician)

PHYSICIAN ASSISTANT SCOPE OF PRACTICE

WOMEN'S HEALTH CARE SERVICES FLETCHER ALLEN HEALTH CARE 111 COLCHESTER AVENUE BURLINGTON, VT 05401

a) **NARRATIVE**

Fletcher Allen Health Care, Women's Health Care Services is composed of a team of professionals who provide the full scope of OB/GYN services. Physicians certified nurse midwives, nurse practitioners and now a physician assistant work in collaborative arrangement. The physician assistant will provide GYN and OB care to our patient population, as do our existing providers. Resident physicians and students rotate through the Women's Health Care Services during their training.

Physician Assistants practice under the supervision of attending OB/GYN physicians. The primary role of the PA is to provide ongoing care for female patients as determined by the PA's training and experience and by the services provided by the supervising physicians. In addition, Pas are involved in both didactic and clinical training of students.

b) **SUPERVISION**

Supervision of the PA is provided by the primary supervising physicians or one of the secondary supervising physicians when the primary supervising physicians are not available. One of the primary or secondary supervising physicians is available 24 hours a day, 7 days a week. Supervision may include the following mechanisms:

- 1. direct supervision by an attending physician
- 2. consultation with an attending physician in person or by phone
- 3. retrospective chart review
- 4. participation in Women's Health Services quality assurance meetings

c) SITES OF PRACTICE

Fletcher Allen Health Care, Women's Health Care Services:

MCHV Campus, 111 Colchester Avenue, Burlington, VT

UHC Campus, 1 South Prospect Street, Burlington, VT

UHC at Blair Park, Williston, VT

d) TASKS

The following list is intended to express a sense of involvement in medical care provision and is not intended to be all inclusive or limiting, except as specifically excluded by the Board of Medical Practice, health care facility, or law. At no time will the physician assistant function in a capacity that exceeds the normal scope of practice of the supervising physicians. The supervising physician may delegate any and all other tasks that by reason of training and experience, the PA can be expected to perform.

- 1. elicit patient histories
- 2. perform physical examinations
- 3. order laboratory exams, radiographic imaging and other diagnostic testing
- 4. write nursing and other therapeutic orders to be carried out in accordance with hospital policy
- 5. interpret diagnostic and screening studies
- 6. provide telephone advice
- 7. provide education and counseling of patients and arrange for follow-up care and referrals
- 8. perform euglycemic clamps
- 9. perform routine gynecologic and obstetric tests, including, but not limited to Pap smears, endometrial biopsies, vulvar biopsies
- 10. insert IV lines, catheters, obtain venous and arterial blood samples
- 11. administer or dispense medication in accordance with hospital policy
- 12. assist in gynecologic surgeries
- 13. initiate resuscitative measures in accordance with ACLS standards and hospital policy
- 14. write prescriptions for medications, including controlled drugs and devices in accordance with Vermont law and DEA regulations

e) PRESCRIPTIVE PRACTICE

The PA named in this document is authorized to prescribe medications, including controlled drugs, in accordance with this scope of practice, as approved by the Vermont Board of Medical Practice. The PA's DEA number is MS 1428

Stephenie Stahl	12/2V 04	
Signature of Physician Assistant	Date	
Clay ly	12/20/4	
Signature of Supervising Physician	Date	

- 1. elicit patient histories
- 2. perform physical examinations
- 3. order laboratory exams, radiographic imaging and other diagnostic testing
- 4. write nursing and other therapeutic orders to be carried out in accordance with hospital policy
- 5. interpret diagnostic and screening studies
- 6. provide telephone advice
- 7. provide education and counseling of patients and arrange for follow-up care and referrals
- 8. perform euglycemic clamps
- 9. perform routine gynecologic and obstetric tests, including, but not limited to Pap smears, endometrial biopsies, vulvar biopsies
- 10. insert IV lines, catheters, obtain venous and arterial blood samples
- 11. administer or dispense medication in accordance with hospital policy
- 12. assist in gynecologic surgeries
- 13. initiate resuscitative measures in accordance with ACLS standards and hospital policy
- 14. write prescriptions for medications, including controlled drugs and devices in accordance with Vermont law and DEA regulations

e) PRESCRIPTIVE PRACTICE

The PA named in this document is authorized to prescribe medications, including controlled drugs, in accordance with this scope of practice, as approved by the Vermont Board of Medical Practice. The PA's DEA number is MS 1957428

Stephenic Stahl	12/2/04
Signature of Physician Assistant	Date
Chy h	12/2014
Signature of Supervising Physician	Date

3979

Please print. Incomplete applications will be returned. Attach additional sheets as needed.
Name in full 1520 Anns Course (First) (First) VEXWONT WOMEN'S
Mailing Address TI KNIGHT LAWE WELLNES
(Street) (City/State) (Street) (Zip Code) (Telephone Number)
Vermont License #: 47 - 000 87 39
Hospital(s) where you have privileges: Hospital(s) Location Specialty
FAIR FURLWOOD, UT OS 164N
CEDTIFICATE OF SECONDA DAY CHIDEDANGERICA DESCRIPTION OF ANY
CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of STATION P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted.
I further certify that I have read the statutes and Board rules governing physician assistants. (Date) (Signature of Secondary Supervising Physician)
JAN 2 3 2012

Stephone Stati 055-0030719

Please print. Incomplete	applications will b	e returned. Attach additiona	l sheets as needed.	
	ulon .	Hishalah		
I)	Last)	(First)	(Middle)	
Mailing Address	39 Beaumont	Office Name)	-	• •
A	aunto Andriado Antonio de Santo de Carlos de C	(Charab)		
じゅん(MA) (City/State)			<u>(656-2886</u> ephone Number)	
Vermont License #:		(202		
		TT 14-5/-> T 4*.	G	
Hospital(s) where you h	iave privileges:	Hospital(s) Location	on Specialty	_
	*			_
List all physician's assi	stants names and ac	idresses you currently superv	rise:	_
	ie Sahl			<u>-</u> -
		ARTAG		- -
	CERTIFICATE O	F SECONDARY SUPERV	ISING PHYSICIAN	
		Chapter 31, I shall be legally respor when the primary supervising phy		
aforesaid Physician Assistan	it. I further certify that	the protocol outlining the scope of accordance with 26 VSA, Chapter	f practice, attached to this app	plication, does not
I further certify that I have r	ead the statutes and Bo	ard rules governing physician assis		
F20-12	·	MWMILLA KI	MUV	
(Date)		Signature of Secondary Supe	rvising Physician)	
		Ø.		
		Special control of the control of th	en per en	Maria can construence unage

Please print. Incomplete application	ns will be retu	rned. Attach additional	sheets as needed.	
Name in full Brock (Last)				
(Last)		(First)	(Middle)	
Mailing Address	Vermont	Cynecology ica Nama)		
1775				
Sugar	(Stre	oet)		
(City/State)	7 0596 (Zin Code)	<u>53</u> (Tolow	2428-4663	
Vermont License #: <u>042-00</u>	10441	(Telef	phone Number)	
Hospital(s) where you have privileg	es:	Hospital(s) Location	Specialty	
List all physician's assistants names	and addresses	s you currently supervise	2:	•
CERTIFICA	TE OF SEC	ONDARY SUPERVIS	ING PHYSICIAN	
hereby certify that, in accordance with 26 p. aforesaid Physician Assistant. I further cert exceed the normal limits of my practice and open posted.	VSA, Chapter 31 A. only when the	I, I shall be legally responsible primary supervising physic	le for all medical activities ian is unavailable and only	when consulted by the
further certify that I have read the statutes	and Board rules	governing physician assistan	te	
1/12/2012	<"			
(Date)	< (Sign	pature of Secondary Supervis	ing Physician)	

Please print. Incom	nplete applications w	rill be returned. Attacl	h additional sheet	s as needed	
Name in full	Flaherty (Last)	Kora		s as needed.	
	(Last)	(First)		(Middle)	
Mailing Address	Chan	Office Name)		(
	55 Main	Office Name)			•
Essix	Junition VT	(Street) 0545 1 p Code)	(80)	879-1802	
(City/State)	(Zi	ip Code)	(Telephone		
Vermont License #:	042-0015	70	· · · · · · · · · · · · · · · · · · ·	/	
Hospital(s) where y	ou have privileges: - A I+ C	Hospital(s Burlington	s) Location V	Specialty 06/6yn)
List all physician's a	assistants names and	addresses you current S上れり	ly supervise:		
aforesaid Physician Assi	ccordance with 26 VSA,	OF SECONDARY S Chapter 31, I shall be legally when the primary super at the protocol outlining the naccordance with 26 VSA	ally responsible for a vising physician is u	all medical activities navailable and only	when consulted by the
I further certify that I have	ve read the statutes and B	oard rules governing phys	ician assistants.		
12-20- (Date)		Ka	dary Supervising Phy	Mer Sician)	
	IAN GO	of the same of the			

2002/002

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE 108 CHERRY STREET BURLINGTON, VT 05401 (802) 657-4220

Please print. In	complete applications wi	ll be returned. Attach addi	tional sheets as needed.	
Name in full	Boyman	(First)	MARGARE	- T
	(Last)	(First)	(Middle	·)
Mailing Addres	s Vernont ((Office Name) (Street) (Street) (Description of the code)		·
- 1775	Milliston R.	(Office Name)	S Probability (1 a tr	e is the lide to took Management for the line of the l
So. Burline	ston VT 05%	(Street)	02 735 125	
(City/St	ate) (Z	ip Code)	(Telephone Number)	- Commission
	se#: <u>042 - 001</u> 05.			
Hospital(s) who	ere you have privileges:	Hospital(s) Lo	cation Special	ty e=0(08)
Steph		OF SECONDARY SUPI		
aforesaid Physicia exceed the normal been posted.	at, in accordance with 26 VSA ————————————————————————————————————	A, Chapter 31, I shall be legally ronly when the primary supervisin hat the protocol outlining the section accordance with 26 VSA, Chapter Tules governing physician	responsible for all medical a g physician is unavailable a ope of practice, attached to t napter 31, Section 1741, the	ctivities of nd only when consulted by the this application, does not
2/7/ _(Date)		(Signature of Secondary		

30R

Please print. Incomplete ap	plications will be a	returned. Attach	additional she	ets as needed	
Name in full This (Last)	boult	Ani	Jan Dile	ots as needed.	
(Last)		(First)		(Middle)	•
Mailing Address		- · 		(widdie)	
185	((Office Name)	-		
South Burling (City/State)	to 17 0	Street) 5403	(KV 21	867-732x	
(City/State)	(Zip Code	e)	(Telephon	KLフ-つ338 e Number)	
Vermont License #: 042	-0010606	?			
Hospital(s) where you have p		Hospital(s)	Location	Specialty	
List all physician's assistants					
aforesaid Physician Assistant. I furtexceed the normal limits of my praceen posted.	her certify that the pro- tice and that in accord	31, I shall be legal the primary superviotocol outlining the lance with 26 VSA,	ly responsible for sing physician is scope of practice, Chapter 31, Secti	all medical activities	,
further certify that I have read the s		es governing physic	likain	Wysician)	
	particular comprehension		Account Name of the Control of the C		

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed. Name in full (First) (Middle) Mailing Address Fletcher Allen Health Core Woman's Health Care Ser (Office Name)

111 Corchester Aug 4st Flor Acc Mon Pavillon

(Street)

(Street)

(City/State)

(Zip Code)

(Telephone Number) Vermont License #: <u>042 - 6010961</u> 10174 Hospital(s) where you have privileges: Hospital(s) Location Specialty List all physician's assistants names and addresses you currently supervise: CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Stephan - Sahl, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted. I further certify that I have read the statutes and Board rules governing physician assistants. (Signature of Secondary Supervising Physician)

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



2012 PHYSICIAN ASSISTANT LICENSURE RENEWAL APPLICATION

PARTI

License # 055-0030719

3. Mailing Address(es):	
FAHC-Womens Health Care Services 111 Colchester Avenue 4th Floor BURLINGTON VT 05401	JAN - 6 2012
4. Home Address:	and the second property of the second propert
City, State, Zip Code:	Section of the sectio
5. Email Address:	
6. Daytime Telephone Number: Area Code:	
7. Date of Birth:	•
B. Place of Birth:	
. Certification Examination Taken – (Check box and enter date of	examination):
$ \sqrt{2} \left(\frac{\partial^{\ell} \sqrt{22}/29}{2} \right) $ NCCPA	
□ (//) State Examination-Identify state:	
Other Examination specify:	
10. Basis for Vermont Certification – (Check box):	
 Apprenticeship Trained University Trained 	
1. Do you have hospital privileges in Vermont? ☐ Yes ☐ No Hospital Name(s) and Location(s):	
Fletcher Allen (FAHC, MCHV) Burlington, VT	

াহ্য In what year did you start গ	working as a physician assista	nt in Vermont?	1664	
13. Were you in active clinical	practice in Vermont during the	e past 12 months?	¥ Yes □ No	· · · · · · · · · · · · · · · · · · ·
14. Other states where you no Application is in	w hold an active certification of Process in New York, License # 015404-1	or license to practic	ce: Week who after	Died license
15. States where you previous	ly were certified or licensed to	practice:		
16. Specialty: Супсыноч,	Gyn. Dheology DEA	Number: M Sto	57428	· -
17. Name and office address	of current EMPLOYER(S):			
FAHC Womens Heat	n Care Services, 111 Colchest	er Avenue, Burling	iton, Vt 05401	
Name	Ad	dress		
18. Please list (use additional PRIMARY and SECONDARY Primary Supervising Physician	SUPERVISING PHYSICIAN(S	nd address(es) of 3). Attach signed s	physicians who currentl heets for each practice	y serve as your location.
Name	Address			
Cheuns Wons, Mo	Worms HES, Gynes	issic Ohedosy	III Colchate Au Burlington VT	L. HE Floor ACLMI
Secondary Supervising Physic	ian(s):			
Name	Address			
See Altached 11st		0		
19. Delegation Agreement: The the most current delegation and procedures. Please re	e Board of Medical Practice re n agreement for your practice eview, date and sign your dele	setting, paving atte	ention to any additions of	or deletions in duties

- PHYSICIAN sign it as well. Attach a copy of your signed delegation agreement to this application. This should be done for each practice location and included with this renewal.
 - a. Has there been a change in your delegation agreement which has not been reviewed by the Board? ☐ Yes ☑ No
- 20. Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a Physician Assistant within the past twelve months.
- 21. Continuing Medical Education (CME) requirements:
 - a. NCCPA certified Physician Assistant: Attach proof of current NCCPA certification; this will serve as adequate proof of CME completion.
 - b. For all others, an explanation of requirements and a CME Record form must be completed.
- 22. Primary Supervising Physician and Second Supervisory Physician forms are provided. They must be completed and returned with this application.

PART II

-"Yes	s" answers	s to Questio	ns 23 - 47 re	equire an ex	planation or	n Form A.		•				
23.		ever applie	d for and be	en denied a	ı certificate t	to practice	medicine	or any oth	er healing	art?		
24. F	lave you	ever withdra	awn an appli	cation for a	certificate to	o practice	medicine	or any othe	er healing :	art?		
	□ yes)s∠no		•					-			
25. H lieu d	Have you of disciplin	ever volunta	arily suspend or any other	led, surrend reason? _{\(\)}	lered or resi	igned a ce	ertificate to	practice n	nedicine or	r any othe	r healing ar	t in
	□ yes	∕g∕no										
gove	rnmental	rmal discipl authority, b or local)?	inary charge y any hospit	s pending o al or health	r has any di care facility,	isciplinary , or by any	action eve professio	er been tak nal medica	en agains Il associati	t you by a ion (interr	iny national,	
	□ yes	y≼no										
27. H	łave you	ever been d	enied the pr	ivilege of ta	king an exa	mination l	pefore any	state med	ical exami	ning boar	d?	
	□ yes	' _{j⊠} no										
28. F	łave you	ever discont	tinued your e	education, tr	aining, or p	ractice for	a period o	of more tha	n three me	onths?		
	□ yes	' _≸ no										
29. F	łave you	ever been d	ismissed or	suspended	from, or asl	ked to lea	ve a reside	ency trainir	g program	n before c	ompletion?	
	□ yes	'⊯ no			•	•					·	
30. F reduct you?	ced, susp	ever had sta ended or re	off privileges voked, or re	, employme signed from	nt or appoin a medical s	ntment in a staff after	a hospital d a complai	or other he nt or peer r	alth care ir eview acti	nstitution on was ir	denied, iitiated agair	ıst
	□ yes	≽rno		.*								
31. F	las your p	orivilege to p or surrender	ossess, disp ed to any jur	ense or pre isdiction or	escribe cont federal age	rolled sub	stances e	ver been s	uspended,	revoked	denied, or	
32. D	□ yes o you cui cribing yo	rrently or ha	ve you ever using electro	prescribed nic medical	any prescrip I records in t	otion medi your pract	cation ove	r the interr	et? This d	loes not i	nclude	
	□ yes	j∝no		-								
33. A	re you pr	esently or h	ave you eve	r been a de	fendant in a	criminal p	oroceeding	j ?				
	□ yes	j⊈,no		•								
						PART II	1				٠	
	(Unless	otherwise or	dered by a	court, your r	esponses to disc	the ques	tions in Pa	art III are co	onsidered	exempt fi	rom public	
Any "	yes" resp	onse to the	questions b	elow must b	e fully expla	ained on t	he enclose	ed Form A.				
34. T charg	o your kn jed as of	owledge, ar the date of t	e you the su his applicati	bject of an i	nvestigation	n by any o	ther licens	ing board	under whic	ch you ha	ve not been	
35. T	o your kn	owledge, ar	e you presei	ntly the subi	ect of a crin	ninal inve	stigation u	nder which	you have	not been	charged?	
	The fo	llowing defir	nitions are p	rovided to a	ssist you in	answerin	g question	s 36 throug	jh 38.			

"Ability to practice medicine" - This term includes:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and

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

The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

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

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

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

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

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

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

37. 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?

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

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

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

IMPORTANT

Since 1999, Board fees have been used to create and maintain the Vermont Practitioners Health Program, a confidential program for the identification, treatment and rehabilitation of practitioners, including physician assistants, affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line).

Part IV - Statutory Profile Questions

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

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 39 through 44 have changed since your last application. We cannot process your application

without	them.
---------	-------

Stephone Stehn Line 055. W20119

39.	Criminal Convictions [S	See 26 VSA § 1368(a)(1)]	∴ Check here if non	e 180 1/21/5			
	Please provide a de tickets) of which you for each matter.	escription of all crimes (felo have been convicted within	nies and misdemeano the past 10 years Ple a	rs; this includes DUI b ase provide complete	ut not sp copies	eeding or pa of document	irking ation
				en (Aprile en en Elita de Aprile en	JAN	1 2 2012	Commercial State of the Commer
	(Conviction Date)	(Court)	(City/State)	(Crime)	The second secon	one can establish compression can FO FORESCE CO POOSEC	or and the second of the secon
40.	Nolo Contendere/Matte	rs Continued [See 26 VSA	§ 1368(a)(2)] 💢 C	heck here if none	D 1/61	12	and a contraction
	sufficient facts of gu	escription of all charges to ilt were found and the matt mplete copies of documer	er was continued with	out a finding by a cour	I not con	ntest it") or w petent jurisdic	vhere ction.
	(Conviction Date)	(Court)	(City/State)	(Charge)		•	
41.	Vermont Board of Medic	cal Practice Matters [See 26	6 VSA § 1368(a)(3)]	Check here if no	one 🖄	0. 116/12	
	Please provide a de Practice (including s	scription of all formal charg tipulations), and final dispo	es served, findings, co sition of such matters l	nclusions, and orders by the courts, if appeal	of the Bo	oard of Medic	cal
	(Date)	(Final	Disposition - Summary	/)		- ,	
42.	Licensing or Certificatio	n Authority Matters in Other e	States [See 26 VSA	§ 1368(a)(4)]			
	findings, conclusions	escription of all formal char s, and orders of such autho e provide complete copie	rities, and final disposi	tion of such matters by	orities of the cou	f other states rts, if appeale	s, the ed, in
(Da	te of Final Disposition)	(Licensing or Certification	Authority) (Court)	(City/State) (Nature of	Charge)	
43.	Restriction of Hospital P	rivileges [See 26 VSA § 13	368(a)(5)] ☆ Cl	heck here if none			
	Revocation/Involunt	ary Restrictions					
	competence or char	scription of any revocation racter and were issued by cess (opportunity for hea each matter.	the hospital's governin	ig body or any other o	fficial of	the hospital	after
	(Date) (H	lospital) (State) (I	Nature of Restriction)	(Reason for Restricti	on)		
	B. Other Restr	ictions \(\noting Check here	if none				
	privileges at a hospit	scription of all resignations al taken in lieu of, or in settle ase provide complete cop	ement of, a pending disc	ciplinary case related to	ership o compe	r the restriction tence or chara	on of acter

	(Date)			(Hospi	ital)	(State)	
	□ In s	re of Action) ettlement on for Action)			(Action)		🗆 In lieu
.44. M	edical M	lalpractice Court	t Judgments/So	ettlements	[See 26 VSA § 1368	B(a)(6A)]	
	Α.	<u>Judgments</u>	Check he	re if none			
		against you ar payment date complete cor	nd all medical r) in which a pa	nalpractice yment was entation, t	arbitration awards a awarded to a compl	otion of all medical malpracing gainst you within the past 1 aining party if not listed belo position and, if possible, a	0 years (10 years from
		None reporte	d				
•		□ Judgment	☐ Arbitration	1			
		(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Again	st You)
		□ Judgment	□ Arbitration)			
		(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Again	st You)
	B.	Settlements	Check her	e if none			
		years (10 year below. Please	s from paymer	nt date) in v plete copie	which a payment was es of documentatio	alpractice claims against yo s awarded to a complaining n, to include final disposi	party if not listed
		None reporte	d				
		(Date)	(Court)	(State)	(A	mount of Settlement Agains	st You)
		(Date)	(Court)	(State)	(A	mount of Settlement Agains	st You)
		ractice [See 26			004		
W	hat mor	nth and year did	you start pract	icing as a f	Physician Assistant?	400010	
per	mission	ents/Teaching to have this info g appointments	ormation poste	d on the we	eb. (This form follow	#46 is optional. By answers the statutory wording. Sin	ing, you re granting ce most appointments

A. Appointments

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

		Burlingto	on, V I				
		Clinical li	nstructor	•			
		2005					
				, , , , , , , , , , , , , , , , , , ,	F		
		(School)	(City)	(State)	(Nature of Appointment)	From (year) To (year)	<u> </u>
		(School)	(City)	(State)	(Nature of Appointment)	From (year) To (year)	-
	В.	Teaching			•		
	·	Please pro past 10 ye	ovide informa ears.	tion regardi	ng your responsibility for tea	aching graduate medical educat	ion within the
		Universit	y of Vermont				
	1	Burlingto	n, VT				
		Preceptin	ıg Medical St	udents			
		2005		Å	ž.		

	(School	ol/Institution)) (City) (Sta	ite) (Nature of Teaching)) From (year) To (year)	
	Note: / web. i	Answering # Please provi	47 is optional de informatio	. By answei n regarding	ring, you are granting permis your publications in peer-re	ssion to have this information po viewed medical literature within	osted on the the past 10
		reported					
	····		· · · · · · · · · · · · · · · · · · ·	/Dublication			(Titi
		•		(Publicatio	in).	(Year)	
				(Publicatio	n)	(Year)	(Titl
	<u>Activiti</u>	<u>es</u> [See 26	VSA § 1368(a	a)(14)]			
	Note: A web. F	Answering #- Please provid	48 is optional de information	. By answer regarding	ing, you are granting permis your professional or commu	ssion to have this information pounity service activities and award	osted on the
	None i	reported				•	
		7				i i	
				(Activities	or Awards)		
. <u>Р</u>	ractice Se	etting [See	26 VSA § 136		or Awards)		·
). <u>P</u>		-	26 VSA § 136	8(a)(15)]	,	/T	-
. <u>P</u>	What is	-	•	8(a)(15)]	, , , , , , , , , , , , , , , , , , ,	/T	

University of Vermont

JU	ransiauri	4 OSTVICES [OSE 20 VOA § 1506(a)(10)]
	Please Are an	e identify any translating services available at your primary practice location. y translating services available at your primary practice location? 屬 Yes □ No
51. <u>I</u>	<u>الل.</u> Medicaid/N	Please describe the translating services available: None Low o 1-80 humber available for obtaining a translator by phony and New Patients [See 26 VSA § 1368(a)(17)] Medicaid participation None None
	Α.	Medicaid participation Do you participate in the Medicaid program? ☑ Yes ☐ No
	В.	New Medicaid Patients Are you currently accepting new Medicaid patients? ☐ Yes ☐ No
		Part V
here	eby affirm	that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.
Date:	15/5	Applicant's Signature

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

Vermont Department of Health - Board of Medical Practice Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

State	Year		
StateYearYearYearYear			
	S. Carlotte and Car		
Question 25) Voluntarily surrendered or resigned a lice locuments	cense to practice medicine or any healing art		
documents			
State	Year		
Dircumstances			
	•		
Question 26) Disciplinary charges or action - Attach d			
Name of organization involved			
Name of organization involved	Date		
Ouration			
Action taken (circle all that apply)			
01 Revocation of right or privilege	12 Leave of absence		
02 Suspension of right or privilege	13 Withdrawal of an application		
03 Censure	14 Termination or non-renewal of contract		
04 Written reprimand or admonition	15 Medical Records Suspension		
05 Restriction of right or privilege	16 Probation		
06 Non-renewal of right or privilege	17 Assurance of Discontinuance		
07 Fine	18 Consent Agreement		
08 Required performance of public service	19 Letter of Agreement		
09 Education/Training/Counseling/Monitoring	20 Expulsion from Membership		
10 Denial of rights or privilege	21 Reprimand		
11 Resignation	22 Other (specify)		
Dircumstances			
Question 27) Denial of examination privileges - Attach			
state	Year		
Circumstances under which examination privileges denied			
,	`		

(Questions 28 and 29) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s)		
Location of Programs	Year	
	nstitution Staff Privileges, Employment or App	
Location	Year_	
Circumstances	<u> </u>	
· · · · · · · · · · · · · · · · · · ·	ontrolled substances - Attach documents	
Name of organization involved		· · · · · · · · · · · · · · · · · · ·
	Date	
Circumstances of restriction		
·		-
(Question 32) Internet prescribing	·	
Please provide a general description	of your practice of internet prescribing	
	, , , , , , , , , , , , , , , , , , ,	-
(Questions 33 and 35) Criminal Invest	igation - Proceeding - Attach documents	
Court		
City and State		
Charge		
	· · · · · · · · · · · · · · · · · · ·	.
Conviction? Yes No	Date	
Plea?Yes No	Date	

(Question 34) investigation by any other licensing board - Attach documents					
Name of Licensing Board	Date				
Location of Licensing BoardCircumstances					
					(Questions 36-38) Medical condition, treatment, use of chemical or illegal substances Treating organization
Address	Telephone				
Type of diagnosis, condition or treatment - field	d of practice - use of chemical substances				
Dates of illness or dependency					
Dates of treatment	to				
Name of Rehabilitation/Professional Assistance	e or Monitoring Program				
Address	Telephone				
Contact person at Program					

(Question 44) Medical Malpractice Claim

Please provide the following information regarding each instance of all out separately for each claim. Additional sheets may be obtained/used	lleged malpractice. This section should be photo copied and filled I if necessary.
Insurer	
Claimant name	
Description of alleged claim (allegations only): This does not co	
Please indicate: 1. Patient's condition at point of your involvement; 2. Patient's condition at end of treatment; 3. The nature and extent of your involvement with the patient; 4. Your degree of responsibility for the course of treatment in left. 5. Narrative of event.	
If the incident resulted in patient's death, indicate cause of death	n according to autopsy or patient chart:
Your role (circle one):	
01 Anesthesiologist 11 PGY 4 02 Primary Care Physician 12 PGY 5 03 Referring Physician 13 PGY 6 04 Attending Physician 14 PGY 7 05 Consultant Specialist 15 Workmen's 16 Court Psych 17 On-Call Phy 18 PGY 1 18 Group Pract 19 PGY 2 19 Other: Special 19 PGY 3 20 Unknown	/sician titioner/Partner
Your Legal Representative in this matter (include name, address and te	elephone number)
Name	
Firm	
Address	
City, State, Zip	
Phone	
Indicate Decision, Appeal, Settlement, Dismissal: If a Court or Arbitration Panel heard your case, indicate the follow	wing:
Court	,
Court's location	
Docket number	

Date the action was filed				
Decision determined by (check one):	Judge	Jury	Arbitration Panel	
Decision:	Award	d:		
If your case was appealed, indicate the for Date appeal decided: (month, day, year)	ollowing: Date ap	opeal filed (mo	onth, day, year)/_	
If your case was settled, indicate the folio	owing:		-	
Settlement amount paid on your behalf: _				
Total settlement amount:			-	
Date of settlement: (month, day, year)				
Case dismissed against you	Against all defe	endants		
Important: In addition to the above inf and release, or other final disposition	ormation, please of the claim. Th	e attach a co iis informatic	py of the complaint and on can be obtained from	final judgment, settlement your legal representative.
Additional information, if any:				
	- 1			
	·			

State of Vermont

Department of Health

Board of Medical Practice

Statement of Good Standing

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

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

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

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

- (1) 60 days or fewer have elapsed since the date a judgment was issued; or
- (2) the person is in compliance with a repayment plan approved by the judiciary.

Signature:	Day	Du	
Date:	12/28/11	a	

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer questions 1 and 2

		Regarding Child Support
person suppor or liabil approv	certifi t orde lity for ed by	requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the less 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 r as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would breasonable hardship. (15 V.S.A. § 795)
1.	You	must check one of the two statements below regarding child support regardless whether or not you have children: 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.
	٥	or I hereby certify that I am <u>NOT</u> in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".
person returns	certifi have	Regarding Taxes 3 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the es 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 been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)
2.	You	must check one of the two statements below regarding taxes: 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).
	0	I hereby certify that I am <u>NOT</u> in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".
Social S	Securi	ty #* Date of Birth
' The di the Dep	sclos: artme	ure 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 nt of Taxes in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.
		STATEMENT OF APPLICANT
certify nforma	that ti	he information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false romission of information is unlawful and may jeopardize my license/certification/registration status.
Signatu	re of A	Applicant Date 12/28/11

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GYNECOLOGIC ONCOLOGY

MEDICAL CENTER CAMPUS 352MP4 111 Colchester Avenue Burlington, VT 05401 PHONE (802) 847-5110 FAX (802) 847-0496

Gynecologic Oncologists Cheung Wong, MD, Director Emmanuel Soultanakis, MD December 23, 2011

To Whom It May Concern:

Please allow this letter to serve as verification that Stephanie Stahl, P.A.-C has been employed full time as a physician assistant with our practice since February 14, 2005. She works as a physician assistant with our inpatient gynecology and gynecologic oncology service, and also sees patients in our ambulatory care clinic for routine gynecologic care, as well as helping to care for our gynecologic oncology patients who are receiving active treatment and are in long term follow up.

Please feel free to contact me with any questions.

Cheung Wong, MD

Since

Director, Gynecologic Oncology

Fletcher Allen Health Care 111 Colchester Avenue

Burlington, VT 05401

802-847-5110

Personal Certification Record

Stephanie Beth Staht

NCCPA Identification #: 1059860

Initial Certification Date: September 19, 2003

Expiration Date: December 31, 2013

You have outstanding requirements for the 2011-2013 cycle. Use the links below to learn more about how to maintain certification.

CME Info

Certified PAs must earn and log 100 CME hours, including 50 Category I hours.

Earning CME for the 2011-2013 cycle begins on 05/01/2011 and ends on 12/31/2013.

Earning CME for the 2013-2015 cycle begins on 05/01/2013 and ends on 12/31/2015.

You have not logged all required CME for the 2011-2013 cycle.

> Log New CME

> View CMESummary

Exam Notes

Certified PAs can take the recertification exam in the 5th or 6th years of their certification maintenance cycle.

Your 5th Year: 2014 Your 6th Year: 2015

Your Contact Info



Fees & Payments

You have an outstanding balance for the 2011-2013 cycle. Please verify that you have logged your CME hours to earn the \$50 discount before you pay.

> View details about your fees & payments

Legal

You have answered 'no' to the three background questions. No further action will be required.

Important Dates & Deadlines

06/30/2013: Last day to <u>earn and log</u> 2011-2013 CME hours and pay the discounted certification maintenance fee.

12/31/2013: Last day to fulfill any outstanding CME requirements and pay the \$130 certification maintenance fee for the 2011-2013 cycle.

Tools for Marketing Your Credential, click here for more information.

Not registered for a specialty Certificate of Added Qualification (CAQ) yet? Click here to learn how.

Stephanie Stahl, PA-C. VT license # 055-0030719 PHYSICIAN ASSISTANT SCOPE OF PRACTICE

WOMEN'S HEALTH CARE SERVICES FLETCHER ALLEN HEALTH CARE 111 COLCHESTER AVENUE BURLINGTON, VT 05401

a) NARRATIVE

Fletcher Allen Health Care, Women's Health Care Services is composed of a team of professionals who provide the full scope of OB/GYN services. Physicians, certified nurse midwives, nurse practitioners, and a physician assistant work in collaborative arrangement. The physician assistant provides Gyn and OB care to our patient population, as do our existing providers. Resident physicians and students rotate through the Women's Health Care Services during their training.

Physician Assistants practice under the supervision of attending OB/Gyn physicians. The primary role of the PA is to provide ongoing care for female patients as determined by the PA's training and experience and by the services provided by the supervising physicians. In addition, PA's are involved in both didactic and clinical training of students.

b)SUPERVISION

Supervision of the PA is provided by the primary supervising physicians or one of the secondary supervising physicians when caring for their patients. One of the primary or secondary supervising physicians is available 24 hours a day, 7 days a week. Supervision may include the following mechanisms:

- 1) direct supervision by an attending physician
- 2) consultation with an attending physician in person or by phone
- 3) retrospective chart review
- 4) participation in Women's Health Services quality assurance meetings

c) SITES OF PRACTICE

Fletcher Allen Health Care, Women's Health Care Services
MCHV Campus, 111 Colchester Avenue, Burlington, VT
ACC Campus, 4th floor, Main Pavilion, Burlington, VT
Alice Hyde Hospital, Gynecologic Oncology outreach clinic
183 Park St. Suite 8 Malone, NY

d) TASKS

The following list is intended to express a sense of involvement in medical care provision and is not intended to be all inclusive or limiting, except as specifically excluded by the Board of Medical Practice, health care facility, or law. At no time will the physician assistant function in a capacity that exceeds the normal scope of practice of the supervising physicians. The supervising physician may

delegate ay and all tasks that by reason of training and experience, the PA can be expected to perform.

- 1. Elicit patient histories
- 2. Perform physical examinations
- 3. Order laboratory test, radiographic imaging, and other diagnostic testing.
- 4. Write nursing and other therapeutic orders to be carried out in accordance with hospital policy
- 5. Interpret diagnostic and screening studies
- 6. Provide advice over the telephone
- 7. Provide education and counseling of patients and arrange for follow up care and referrals
- 8. Insertion of IUDs
- 9. Perform routine gynecologic and obstetric tests, including, but not limited to pap smears, endometrial biopsies, vulvar biopsies
- 10. Insert IV lines, catheters, obtain venous and arterial blood samples, and nasogastric tubes
- 11. Administer or dispense medication in accordance with hospital policy
- 12. Assist in gynecologic surgeries
- 13. Initiate resuscitative measures in accordance with ACLS standards and hospital policy
- 14. Write prescriptions for medications, including controlled drugs and devices in accordance with Vermont law and DEA regulations.

e) PRESCRIPTIVE PRACTICE

The PA named in this document is authorized to prescribe medications, including controlled drugs, in accordance with this scope of practice as approved by the Vermont Board of Medical Practice. The PA's DEA number is MS 1057428

Signature of Physician Assistant	15/28/11
Signature of Physician Assistant	Date
	1/3/12
Signature of Supervising Physician	Date\ \

Secondary Syperising Physicians for Stephenn Stoll, Par 057.0030719

Primary

MD	Practice	Signed
Cheung Wong	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	300
Elizabeth Bonney	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	V
Robert Hayward	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	Separat.
Elisabeth Wegner	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	W.
Roger Young	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Eleanor Capeless	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	3/
David Jones	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Marjorie Meyer	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Mark Phillippe	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
John Brumsted	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	V _
Peter Casson	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	li marie
Christine Murray	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Emmanuel Soultanakis	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Stephen Brown	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	jazzan
Tracy Maurer	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	V
Ira Bernstein	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Diane Charland	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Elise Everett	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	1
Christy Broadwell	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Erica Hammer	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Brian Nielsen	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Julie Phillips	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Renju Raj	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	Sand Sand
George Till	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Hishalah Zvulon	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Anne Viselli	Vermont Urogynecology, 71 Knight lane, Suite 1. Williston, VT 05495	
444		
Patrick Clifford	Affiliates in OB Gyn, 96 Colchester Ave, Burlington VT 05401	No.
Dale LaCroix	Affiliates in OB Gyn, 96 Colchester Ave, Burlington VT 05401	
Kimberly Blake	Affiliates in OB Gyn, 96 Colchester Ave, Burlington VT 05401	
Greta Hanson	Affiliates in OB Gyn, 96 Colchester Ave, Burlington VT 05401	
John Gallagher	Champlain OB Gyn, 55 Main Street, Essex Junction VT 05452	

Jill Jertson	Champlain OB Gyn, 55 Main Street, Essex Junction VT 05452	<u> </u>
Sally Stockwell	Champlain OB Gyn, 55 Main Street, Essex Junction VT 05452	
Kara Flaherty	Champlain OB Gyn, 55 Main Street, Essex Junction VT 05452	
Paula Miner	Champlain OB Gyn, 55 Main Street, Essex Junction VT 05452	V
Maria Carracino	Champlain OB Gyn, 55 Main Street, Essex Junction VT 05452	
		MMWM
Amy Thibault	Maitri 185 Tilley Drive, South Burlington, VT 05403	
Julia Brock	Maitri 185 Tilley Drive, South Burlington, VT 05403	
Jennie Lowell	Maitri 185 Tilley Drive, South Burlington, VT 05403	LV
Julie Wade	Maitri 185 Tilley Drive, South Burlington, VT 05403	
Rosa Mojdehi	Maitri 185 Tilley Drive, South Burlington, VT 05403	
		MANNINA
Chery Gibson	Vt women's Choice 1775 Williston Road, Suite 110, South Burlington, VT	05403 🗸
Kym Boyman	Vt women's Choice 1775 Williston Road, Suite 110, South Burlington, VT	05403
Susan Smith	Vt women's Choice 1775 Williston Road, Suite 110, South Burlington, VT	05403 🎺
Julia Brock	Vt women's Choice 1775 Williston Road, Suite 110, South Burlington, VT	05403
Nancy Fisher (cr/30h		

Former supervising physicians

Gamal Eltabbakh	Lake Champlain Gynecologic Oncology, 364 dorset Street. So Burlington, VT 05403
Kristen Wright	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401
Daniel Riddick	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401
Jule LaCombe	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401
Peter Cherouny	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401

Please print. Incomp	lete application	is will be i	returned.	Attach add	itiona	l sheets	as needed.	
Name in full	Soultanale	٠ ١	Emme	inuel				
	(Last)		(Fi	rst)			(Middle)	
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III Colchi	te Azehue	4+n \$(Office Na	me) - Mari Pa	برد. د کا اُلحاق			
Mailing Address		VT (Street)		(40	8 PC	47-5113	
(City/State)		(Zip Coo	le)		(Tele	phone	Number)	
Vermont License #: _							·	
Hospital(s) where you	u have privilego			spital(s) Lo	ocation V T	1	Specialty	<u></u> ጅ
List all physician's as	ssistants names	and addre	esses you	currently su	ıpervi	se:		
	CERTIFICA						***	- -
I hereby certify that, in according to the state of the s	tant. I further cert	A. only whe	en the prima protocol ou	ary supervisin tlining the sco	g physi one of r	ician is u practice	navailable and only	when consulted by the
further certify that I have	•	and Board r	ules govern	ning physician	Assista	ants.		
1/10/12 (Date)			(Signature	Secondary	Simery	vi≼ino Phy	vsician)	
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SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed. Name in full Dione (First) (Middle) Mailing Address Fletcher Allen Health Cori Libran's Health Care Service (Office Name) (Ottice Name)

(Ottice Name)

(Street)

(Street)

(City/State)

(Ottice Name)

(Ottice Name)

(Street)

(Street)

(Street)

(Telephone Number) Vermont License #: _ 0 42 00 100 80 Hospital(s) where you have privileges: Hospital(s) Location Specialty List all physician's assistants names and addresses you currently supervise: CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Stephanic Sahi , P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted. I further certify that I have read the statutes and Board rules governing physician assistants.

printe Printe Printe	ipiete applications will be	returned. Attach	additional shee	ts as needed.	
Name in full	(Last)		Dale	Jeanne (Middle)	
	•	()		(Middle)	
Mailing Address	Affiliates in	08-646			
	Affiliates in 96 Colchester Ave	(Office Name)	-	And the second s	
Bushia	ton VT 05 (Zip Co	(Street)	0		
(City/State)	70m V 1 05	401		C28- AJ41	
(City/btate)	(Zip Co	dej	(Telephone	Number)	
Vermont License #:	04200 10133				
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List all physician's a	ssistants names and addr	esses you currentl	y supervise:		
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aforesaid Physician Assis	ccordance with 26 VSA, Chap Aak (, P.A. only who stant. I further certify that the of my practice and that in accordance	on the primary superv	using physician is u	mavailable and only whe	n consulted by the on, does not vsician assistant has
further certify that I hav	e read the statutes and Board	ules governing physi-	cian assistants.	ų.	
12(16/11 (Date)		D ROW (Signature of Second	Ary Supervising De	ugician	·
) outon vising Fil	y sicially	

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

Name in full	Murray		ft	TOTAL TITLE			
	(Last)		Christin	<u> </u>			
	(Last)		(First)		(N	Aiddle)	
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Mailing Address	Fletcher	Allen Health	h Cori	libran o	Health (Care Stru	irat.
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(City/State)		(Zip Code)		(Teleph	ione Num	iber)	
Vermont License #:						•	
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I hereby certify that, in a	ccordance with 26	VSA, Chapter 31,	, I shall be le	egally responsibl	e for all me	dical activities	of
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arotesara i mysteram 1722	stant, i furmer ceri	niv inai ine protoc	col outlining	the scope of pra	ictice attacl	hed to this anni-	cotion de
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been posted.							
I further certify that I have	va raad tha stabites	and Daguet		A : A	1		
rature corney mat I ha	ve read the statutes	and Board rules g	governing ph	iysician assistant	# . X		
1/3/2012			/	111/11/	[]/[[]		
(Date)		/ pr •		MAMULA MU	WHILL		
(Date)		(Signa	ature of Sec	ondary Supervisi	ing Phys ici e	a n)	

PRIMARY SUPERVISING PHYSICIAN APPLICATION

· ·		tions will be returned. At		as needed.
Name in full	Wary	Cheo (First)	nς	
- 111	(Last)	(First))	(Middle)
Mailing Address _	FAHC-	Avenue, (Street)	on of byneodyn	Ducobyy
	Colchoto	Aucros 4th Floor	e) Acc mp	
Bur Ilaston	, V7	(Street) (Sip Code)	(800) 847-	5110
(City/State	e)	(Zip Code)	(Telephone N	Number)
Vermont License	#: <u>042-0</u>	009968		
Hospital(s) where FAHC	•	leges: Hospi	ital(s) Location Burnales VT 0540	Specialty Gyn - October
Alice Hyde O	r Naspital Nedical Center	138 Fisher Room - 183 Park Street	Bestin, UT DS602 Molone NY	Gyn - Oncology Gyn - Oncology
		de for supervision when y	you are not available or	r out of town:
	C	ERTIFICATE OF SUPI	ERVISING PHYSICI	IAN
I hereby certify that, i	n accordance with	26 VSA, Chapter 31, I shall b , P.A. while under my supervi	e legally responsible for all sion. I further certify that	I medical activities of the protocol outlining the scope of
practice, attached to the	his application, do	pes not exceed the normal limit be with 26 VSA, Chapter 21, S	s of my practice. I further	certify that notice will be posted that
I further certify that I	have read the stat	utes and Board rules governing	physician assistants.	
12/16/11	· · · · · · · · · · · · · · · · · · ·			
(Date)		(Signature of	f Supervising Physician)	
		Co-signature of PA:	tinh Itel	

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number 1995によっていることによっている。

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

Name in full Granter Italian (First) (Middle)

Mailing Address Flatch. Alla Health Core beaution (Office Name)

White Collaborate Aug 1/2 Flor Alla Mealth Core beaution (Office Name)

(Street) (Street)

(City/State) (Zip Code) (Telephone Number)

Vermont License #: 042 - 0007565

Hospital(s) where you have privileges: Hospital(s) Location Specialty

List all physician's assistants names and addresses you currently supervise:

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Stephan Solution. P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted.

I further certify that I have read the statutes and Board rules governing physician assistants.

/2/8//1

(Signature of Secondary Supervising Physician)

Please print. Incomp	lete applications will	be returned. Attac	h additional she	ets as needed.	
Name in full	(Jact)	Kimberle			
				(Middle)	
Mailing Address	Affiliates in	~ OB-646			
Mailing Address	96 Colchister Au	(Office Name)			
Burlingt	on VT	(Street)	8000	LEX 6791	
(City/State)	(Zip (Code)	(Telephon	e Number)	
Vermont License #: _	042-000880	5	(F		
Hospital(s) where you	ı have privileges:	Hospital(s) Location	Specialty 6 13 1	64N
List all physician's as Steph	sistants names and ad		ly supervise:		
	CERTIFICATE O	F SECONDARY S	SUPERVISING	PHYSICIAN	
hereby certify that, in according to the control of	cordance with 26 VSA, Chack P.A. only ant. I further certify that the	napter 31, I shall be leg	ally responsible for vising physician is	all medical activities unavailable and only	when consulted by the
further certify that I have	read the statutes and Boa	rd rules governing phy	sician assistants.	7 .	
(Date)	•		7		
(Date)	M.A	(Signature of Secon	dary Supervising P	hysician)	

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed. Name in full Elizebeth (First) (Middle) Mailing Address Fletcher Alla Health Con Librario Health Care Server Vermont License #: <u>042 - 00 10 491</u> Hospital(s) where you have privileges: Hospital(s) Location Specialty List all physician's assistants names and addresses you currently supervise: CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Stephan Sold , P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted. I further certify that I have read the statutes and Board rules governing physician assistants

(Signature of Secondary Supervising Physician)

Please print. Incom	nplete applications w	ill be returned. A	ttach additional she	ets as needed.	
Name in full	Groodwell	Ct (33)	* ***		1
-	(Last)	(Firs	t)	(Middle)	
Mailing Address	FANC- L	Domen's MCS			
	III Colchester	(Office Nan	ie)		
Burling	für VT	(Street)		547-1400	
(City/State)	(Z	ip Code)	(Telepho	ne Number)	
Vermont License #	: 042-0011584			•	
Hospital(s) where y	ou have privileges:	Hos	pital(s) Location	Specialty	
List all physician's	assistants names and	l addresses you c	urrently supervise:		-
aforesaid Physician Assexceed the normal limit been posted.	accordance with 26 VSA	A, Chapter 31, I shall only when the primar that the protocol outl t in accordance with Board rules governi	y supervising physician ining the scope of practi 26 VSA, Chapter 31, So	for all medical activities is unavailable and only ice, attached to this appection 1741, the use of	when consulted by the

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed. Name in full (Middle) Vermont License #: <u>042-00///86</u> Hospital(s) where you have privileges: Hospital(s) Location Specialty List all physician's assistants names and addresses you currently supervise: CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Stephan: Sold, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted. I further certify that I have read the statutes and Board rules governing physician assistants. ondary Supervising Physician)

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed. Name in full (Middle) Mailing Address Fletcher Alla Health Con Woman's Health Care Ser:

(Office Name)

(Office Name)

(Street)

(Street)

(City/State)

(Zip Code)

(Telephone Number) Woman's Heelsh Care Server Vermont License #: 042 - 000 7/0/ Hospital(s) where you have privileges: Hospital(s) Location Specialty List all physician's assistants names and addresses you currently supervise: CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Stephan Sahl , P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted. I further certify that I have read the statutes and Board rules governing physician as

(Signature of Secondary Supervising Physician)

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed. (First) (Middle) Name in full (Office Name)

W Colchester Aug 4th Flor Acc Mon Pavilian

(Street)

(City/State)

(Zip Code)

(Street)

(Telephone Number) Vermont License #: 042 - 00065// Hospital(s) where you have privileges: Hospital(s) Location Specialty List all physician's assistants names and addresses you currently supervise: CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Stephane Sahl, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted. I further certify that I have read the statutes and Board rules governing physician assistants (Date)

Please print. Inc		e returned. Attach additional she	ets as needed.	
Name in full	Ecolon Couls	Nauch	A	
	(Last)	Naucy (First)	(Middle)	
Mailing Address	1778 WW	15ton Rd		
		(Office Name)		
S.B.	e) (Zip Co	(Street) OSAOろ		
(City/Stat	e) (Zip Co	ode) (Telephor	ne Number)	
Vermont License	#: 042-008079	•		
	e you have privileges:	Hospital(s) Location	Specialty	
		The state of the s	not f	
	White pointly	resses you currently supervise:		
	CERTIFICATE OF	SECONDARY SUPERVISING	G PHYSICIAN	
aforesald Physician	Assistant. I further certify that the	apter 31, I shall be legally responsible for then the primary supervising physician is the protocol outlining the scope of practic accordance with 26 VSA, Chapter 31, Secondance	s unavailable and only when co	does not
I further certify that l	have read the statutes and Board	d rules governing physician assistants.	•	
2 20 (Date)		(Signature of Secondary Supervising	Physician)	
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Please print. Incomplete applications will be retu	urned. Attach additional she	ets as mooded
	Haria	cts as needed.
Name in full	\ 'p	Com.
(Last)	(First)	(Middle)
Mailing Address Champlain (Off	DB-6	
(Off	fice Name)	
55 Main Strut		
(Street Street S	eet) (802/	879-1802
	(Telephon	e Number)
Vermont License #: 042-0012266		
Hospital(s) where you have privileges: Pletcher Allen Health Care List all physician's assistants names and addresses Stephanie Stahl	<u> </u>	
I hereby certify that, in accordance with 26 VSA, Chapter 3 problems of the protocolor of the protocol	ocol outlining the scope of practice ace with 26 VSA, Chapter 31, Sect	r all medical activities of unavailable and only when consulted by the e, attached to this application, does not ion 1741, the use of a physician assistant has

SECONDARY SUPERVISING PHYSICIAN APPLICATION

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Stephan State Phane P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted.

I further certify that I have read the statutes and Board rules governing physician assistants.

(Date)

(Signature of Secondary Supervising Physician)

riease print. incomp	nete applications will	be returned. Attach	additional she	eets as needed.	
Name in full	Clifford (Last)	Potricle			
	(Last)	(First)		(Middle)	
Mailing Address	Affiliates in	JOB-64L			
	96 Colchister Au	(Office Name)	·		
Burlings	0 TV ~ 0	(Street) 5 4 0 1	. CU8	658-4791	
(City/State)	(Zip (Code)	(Telephor	ne Number)	
Vermont License #:					
Hospital(s) where yo	u have privileges:	Hospital(s)	Location	Specialty	
List all physician's a	ssistants names and ad	dresses you currently	y supervise:		
	CERTIFICATE OI	F SECONDARY SI	JPERVISINO	G PHYSICIAN	
aforesaid Physician Assis	ccordance with 26 VSA, Charles P.A. only stant. I further certify that to f my practice and that in a	when the primary superv he protocol outlining the	ising physician is scope of practic	s unavailable and only to attached to this appli	when consulted by the cation, does not
I further certify that I hav	e read the statutes and Boa	rd rules governing physi	cian assistants.		
17/1	9/11		· Agenta		
(Date)		(Signature of Second	ary Supervising	Physician)	

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

Name in full	EVERETI		NSL	/*************************************	455		
	(Last)		(First)		(Middle)		
Mailing Address	Fletcher	***************************************		libras o Heals	L Care Seri	يهد الألو	
W	Cotchester Po	Office) -۱, 44 Flss		Mor Paullin			
Buch	Colchester A	(Street)		78 KOD	7-1400		
(City/State)		(Zip Code)		(Telephone			
Vermont License #	: 042-001	2288			·		
Hospital(s) where	you have privilege	es:	Hospital	(s) Location	Specialty		
List all physician's	assistants names	and addresses y	ou currer	ntly supervise:			
						- · · ·	
	CERTIFICA	TE OF SECO	VDARY	SUPERVISING 1		- `	
I hereby certify that, in Stephan aforesaid Physician As exceed the normal limit been posted.	accordance with 26.	VSA, Chapter 31, I A. only when the priotoco	shall be le rimary sup	gally responsible for a ervising physician is u	all medical activities mavailable and only attached to this app	when cons	
I further certify that I h	nave read the statutes	and Board rules go	verning ph	ysician assistants.		v	
11/22/11		K	76	Af MI			
(Date)		(Signat	ure of Seco	ondary Supervising Ph	ysician)		

Please print. Incomp	lete applications will b	e returned. Attach ad	ditional sheets	as needed.	
	Gallagher (Last)			(Middle)	
Mailing Address	55 Main 24	(Office Name)	· · · · · · · · · · · · · · · · · · ·		
$\frac{\text{Essix} \text{Z}}{\text{(City/State)}}$	unction VT D	(Street) 5545 1 Code)	(802) Y	579-1852 Jumber)	
	12-007040		•	,	
Hospital(s) where you	have privileges:	Hospital(s) L	ocation	Specialty Specialty	gton UT
List all physician's as	sistants names and add	dresses you currently s	upervise:	069	jn.
aforesaid Physician Assistatesceed the normal limits of the posted.	CERTIFICATE OF cordance with 26 VSA, Chadran P.A. only want. I further certify that the f my practice and that in acceptance with the statutes and Board P. A. of the statutes and Board P. Of the statutes	the primary supervising the scocordance with 26 VSA, C	responsible for all ng physician is una ope of practice, at hapter 31, Section	medical activities available and only tached to this applied 1741, the use of a	when consulted by the

Please print. Incomplete applications will be returned. Attach additional sheets as needed.
Name in full Chert (Last) Chert (Middle)
(Last) (First) (Middle)
Mailing Address Vermont Cynecology (Office Name)
(Office Name)
- 1775 Williston Road Suite 110.
(Office Name) 1775 Williston Road Suite 113 (Street) South Burlington, VT D5463 (City/State) (Zip Code) (Telephone Number)
(City/State) (Zip Code) (Telephone Number)
Vermont License #: VT 7465
Hospital(s) where you have privileges: Hospital(s) Location Specialty
List all physician's assistants names and addresses you currently supervise:
CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted.
I further certify that I have read the statutes and Board rules governing physician assistants.
12/20/11 / Sll us
(Date) ' (Signature of Secondary Supervising Physician)

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

Name in full Mam	MO1-4	Estea			- W. S.
(Las		(First)		(Middle)	
Mailing Address	TAKE- Women	, KCS			
	Colchiste Aug	ffice Name)	C Only		
Bustination	(St D540 (Zip Code	reet)	(802) 84-	1-1400	
(City/State)	(Zip Code)	(Telephone)		
Vermont License #: <u>042</u>	<u>1-00/2103</u>			·	
Hospital(s) where you have	re privileges:	Hospital(s) Lo	ocation	Specialty	
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List all physician's assista	nts names and address	ses you currently s	apervise:		
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CE	RTIFICATE OF SE	CONDARY SUP	ERVISING I	PHYSICIAN	
I hereby certify that, in accorda	nce with 26 VSA, Chapter , P.A. only when I further certify that the pr	r 31, I shall be legally the primary supervising	responsible for a	all medical activities navailable and only attached to this any	y when consulted by the
I further certify that I have read Z G (Date)		les governing physicia	and he was to see the second of the second o	ysician)	

Please print. Incom	uplete applications will be	returned. Attacl	h additional she	ets as needed.	
Name in full	DORPERD Hanson	0	iceta		
	(Last)	(First)		(Middle)	
Mailing Address	Affiliation in	08-646			
	96 Colchister Ave	(Office Name)			
Burling (City/State)			. Cug	658-4791	
		ide)	(Telephor	ne Number)	
Vermont License #:	42001135				*
Hospital(s) where yo	ou have privileges:	Hospital(s) Location	Specialty OB Gyn	
List all physician's a	ssistants names and addr	esses you current	ly supervise:		- -
	CERTIFICATE OF S				· ·
foresaid Physician Assis	ccordance with 26 VSA, Chap Na. (, P.A. only wh stant. I further certify that the of my practice and that in according	en the primary super	vising physician is	unavailable and only	when consulted by the
further certify that I hav	re read the statutes and Board	rules governing phys	ician aggictant-		
12/22/11 (Date)		(Signature of Second			
· ·/		Constitute of Second	arv Supervising P	hysician)	

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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	(Last)		(First)	·	(Middle)	
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Mailing Address	Fletchir	Allen Mealth	Cari	home by Health	. Care Struke	
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Ω		(Street)		(Telephone N		
Land Urt 1 gr	ston UT	05401		128 Ked	- 1400	
(City/State)	,	(Zip Code)		(Telephone N	umber)	
Vermont License #:	042-000	6592				
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Hospital(s) where yo	ou have privileg	es:	Hospital	(s) Location	Specialty	
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List all physician's a	assistants names	and addresses w	011 <i>0</i> 11	- + 1		
isise air physician s	assistants names	and addresses y	ou currei	nuy supervise:		•
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	CERTIFICA	ATE OF SECO	NDARY	SUPERVISING PH	HYSICIAN	
Thomas and C. Al						
I hereby certify that, in a	accordance with 26	VSA, Chapter 31, I	shall be lo	egally responsible for all	medical activities of	
aforesaid Physician Assi	ictant I further car	.A. only when the pr	rımary sup	pervising physician is una	vailable and only wh	en consulted by the
aforesaid Physician Assi exceed the normal limits						
been posted.	practice and	a that hi accordance	WIGH ZO V	5A, Chapter 51, Section	1/41, the use of a ph	ysician assistant has
· · · · · · · · · · · · · · · · · · ·		6 1				
I further certify that I ha	ve read the statutes	and Board rules go	verning pl	ysician assistants		
11/2/1		1//\$	XI.	1	12	
149/1			[]]W[21 0	// / /	
(Date)		// (Signat	ute of Sec	ondary Supervising Phys	ician)	

Please print. Inco	mplete applications wil	l be returned. Attach:	additional sheet	s as needed	
Name in full	(Last)	1)3 %		s as needed.	
	(Last)	(First)		(Middle)	•
Mailing Address_	Champ	lan DB-byn		/	
	55 Main 5	(Office Name)			
Essix	Junition VT	(Street) 0545 1	1008)	879-1802	
		Code)	(Telephone	479 - 1852 Number)	
Vermont License #	1: 042-6009290				
Hospital(s) where	you have privileges:	Hospital(s)	Location	Specialty	
List all physician's	assistants names and ac	ldresses you currently			
atoresaid Physician Acc	accordance with 26 VSA, C P.A. only istant. I further certify that is of my practice and that in a	. Printing Jupot vis	y responsible for al	ll medical activities of	then commit in
	we read the statutes and Boa				
(Date)	1/11	(Signature of Secondar	1/2 /1	sician) /	1/P

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Name in full	Lawell (Last)				
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South	Burington VT	(Street) U5403	(8021	860-7338	
(City/State)	(Zip e	Code)	(Telephone	Number)	
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aforesaid Physician Assi	CERTIFICATE OF CONTROL OF THE PROPERTY OF THE	when the primary supervisi	responsible for ing physician is	all medical activities unavailable and only	when consulted by the
further certify that I have 12 19 1 (Date)	ve read the statutes and Boa	rd rules governing physician for the contract of the contract		ıysician)	

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

Name in full	Moure	75021	PAGE - CONTRACT - CONT		441-			
***************************************	(Last)	(First)		(Middle)	seen.			
Mailing Address		lla Health Con		dollh Care 5	ituke .			
118	Colchester Aug	(Office Name)	More Pevilia	^`	<u> </u>			
Burlin	ston UT	(Office Name) Y'' Flor Acc (Street) 5 401 Zip Code)	(8 w 2)	847-1400				
(City/State)	(2	Zip Code)	(Telepho	ne Number)				
Vermont License #:	042-001017	77						
Hospital(s) where y	ou have privileges:	Hospita	l(s) Location	Specialty				
List all physician's assistants names and addresses you currently supervise:								
	CERTIFICAT	E OF SECONDARY	SUPERVISIN	G PHYSICIAN	·			
aforesaid Physician Ass	istant. I further certify		pervising physician	is unavailable and o	carlos and a second			
I further certify that I ha	ive read the statutes and	d Board rules governing p	hysician assistants. Ondary Supervising	g Physician)	<u> </u>			

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed. Name in full (First) (Middle) Woman's Health Care Service Vermont License #: <u>042-0007</u> 765 Hospital(s) where you have privileges: Hospital(s) Location Specialty List all physician's assistants names and addresses you currently supervise: CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Hephanis Stable and only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted. I further certify that I have read the statutes and Board rules governing physician assistants.

Please print. Incom	plete applications wi	ll be returned. Attach additional	l sheets as needed.		
Name in full	miner	Paula			
Name in full	(Last)	(First)	(Middle)		
Mailing Address	Cho	mplain OB Gyn			
	55 Man	(Office Name)			
Essex	Juneton, VT	(Street)	021879-1802		
(City/State)	(Zi	p Code) (Tele	ephone Number)		
Vermont License #	: <u>042-001</u> 146	lo			
Hospital(s) where you have privileges:		Hospital(s) Location	n Specialty		
FARL		Bralington VT	UB-64N		
List all physician's	assistants names and Lephanie Ste	addresses you currently supervi	se:		
	CERTIFICATE	OF SECONDARY SUPERVI	SING PHYSICIAN		
<u>Sulphane St</u> aforesaid Physician Ass	, P.A. or sistant. I further certify the	, Chapter 31, I shall be legally respons nly when the primary supervising phys nat the protocol outlining the scope of in accordance with 26 VSA, Chapter 3	ician is unavailable and only practice, attached to this appl	when consulted by the ication, does not	
I further certify that I had	ave read the statutes and	Board rules governing physician assist	ants.		
12/20/11	Annual Principal Control of the Cont			A No. 10 to 60 per com a la mass man appropriate.	
(Date)		(Signature or Secondary Supervising Physician)			

Please print. Inco	mplete applications will	be returned. Atta	ch additional shee	ts as needed	
Name in full	(Last)	Rose		The state of the s	
	(Last)	(First)		(Middle)	
Mailing Address _		Marte		,	
	185 Tilley Oriv	(Office Name)			
South	Burlington VT (Zipe	(Street) 05403	(500)	860-7338	
/ (City/State) (Zip (Code)	(Telephone	Number)	
Vermont License	4: 042012010			•	
Hospital(s) where	you have privileges:	Hospita	l(s) Location	Specialty	
					-
List all physician's	assistants names and ad	dresses you curre	ntly supervise:		-
					-
	CERTIFICATE O	F SECONDARY	SUPERVISING	PHYSICIAN	
foresaid Physician As	accordance with 26 VSA, Change P.A. only sistant. I further certify that it sof my practice and that in a	napter 31, I shall be lowhen the primary sup	egally responsible for ervising physician is	all medical activities unavailable and only	when consulted by the
further certify that I h	ave read the statutes and Boar	rd rules governing ph	ysician assistants.		
(Date)		(Signature of Second	ondary Supervising Ph	ysician)	

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed. Name in full (Last) (First) (Middle) (Office Name) (Street) Vermont License #: 042 - 00/2/57 Hospital(s) where you have privileges: Hospital(s) Location Specialty List all physician's assistants names and addresses you currently supervise: CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Stephane Sahi , P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted. I further certify that I have read the statutes and Board rules governing physician assistants.

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

Name in full	Philtippe	**/\^*\/=== -/*\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Mark	· · · · · · · · · · · · · · · · · · ·			7,512-512
	(Last)		(First)		(M	(liddle)	
Mailing Address	Fletcher	Alla Heals	n Cari	Woma's	Health C	lare Service	V
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Burlin.	Lotchester A	(Stree 05 401	et)	Gos	4 847-1	1400	
(City/State)	,	(Zip Code)		(Telep	hone Num	ber)	
Vermont License #:		•					
Hospital(s) where yo	ou have privileg	es:	Hospital	(s) Location	Sp	pecialty	
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List all physician's a	assistants names	and addresses	you curre	ntly supervis	e:		
		ATE OF SECO					
I hereby certify that, in a Stephanic aforesaid Physician Assi exceed the normal limits been posted.	istant. I further cer	A. only when the	primary sup col outlining	pervising physic the scope of p	cian is unavai ractice, attach	lable and only w	when consulted by the
I further certify that I ha	ve read the statutes	and Board rules	governing p	aysician assista	nts.		
12/5/11 (Date)		At	The	the pol	D		
(Date)		(Sign	iature of Sec	ondary Supervi	ising Physicia	an)	

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

Name in full Chilles (First) (Middle)

Mailing Address FAMC - Warman MCS

(Office Name)

(City/State) (Street)

(City/State) (Zip Code) (Telephone Number)

Vermont License #: D42 - 0011596

Hospital(s) where you have privileges: Hospital(s) Location Specialty

List all physician's assistants names and addresses you currently supervise:

(CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Stephane Solution, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted.

I further certify that I have read the statutes and Board rules governing physician assistants.

(Signature of Secondary Supervising Physician)

/2/6/// (Date)

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed. Name in full (Middle) (Street) Vermont License #: <u>042 - 0012086</u> Hospital(s) where you have privileges: Hospital(s) Location Specialty List all physician's assistants names and addresses you currently supervise: CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Stephane Sahe P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted. I further certify that I have read the statutes and Board rules governing physician assistants.

(Signature of Secondary Supervising Physician)

Please print. Incomp	olete applications will	be returned. Attach	additional sheets as ne	eded.
		Suiam		
	Sm. LL (Last)	(First)	(M	iddle)
Mailing Address	Verd	nout Course		·/
Mary gallands,		(Office Name)		The state of the s
	1175 Wi	(Street)	sche No.	
_ South B	tieliaku Itt	(Street)	Smaller	1.4
(City/State)	Urbales, VT (Zip	Code)	(Telephone Numb	7663 er)
Vermont License #: _	042-0005	990	, Parada Communication	•
Hospital(s) where you	u have privileges: Lund Um (†	Hospital(s)	Location Spo Exercise try	ecialty Bloogy recology
List all physician's as	ssistants names and ad	dresses you currently	supervise:	
				· ·
	CERTIFICATE OI	F SECONDARY SU	PERVISING PHYS	ICIAN
aforesaid Physician Assist	cordance with 26 VSA, Ch	napter 31, I shall be legal when the primary supervi	y responsible for all medi sing physician is unavailal	
I further certify that I have	e read the statutes and Boar	rd rules governing physic	ian assistants.	
12/2/	decrease de la constant de la consta		1150. () A	\mathcal{N}
(Date)		(Signature of Seconda	ry Supervising Physician)	WI >

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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	* therefore				
Name in full	1111	له في الله		COMMENSATION OF THE INCOME.	
	(Last)	(Firs	t)	(Middle)	
5 # 111	Vanne C. L. C. L.			·	
Mailing Address	FANC- W				•
	M Colcheste	(Office Nam	e)		
Burling	ton VT	(Street)		47-1400	
(City/State)	(Z	ip Code)	(Telephor	ne Number)	
Vermont License #	: <u>042-000</u> 7	744			
Hospital(s) where y	ou have privileges:	Hosp	oital(s) Location	Specialty	
List all physician's	assistants names and	l addresses you co	arrently supervise:		
					, -
	CERTIFICATE	OF SECONDA	RY SUPERVISIN	G PHYSICIAN	
Stephan -	accordance with 26 VSA	only when the primar	v supervising physician	ic unavailable and only	whom somether the st
	sistant. I further certify t ts of my practice and tha				
I further certify that I h	ave read the statutes and	Board rules governi	ng physician assistants.		
$\frac{14/15/2011}{(Date)}$			200 21	THE NO	7
(Date)		(Signature o	Secondary Supervising	Physician)	

Please print. Incomplete applications wi	ll be returned. Attach ac	lditional sheets	as needed.	
Name in full Wode (Last)	John		MA	
(Last)	(First)		(Middle)	
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further certify that I have read the statutes and Bo $29900000000000000000000000000000000000$		n assistants.	Lens	

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed. Name in full (Middle) Mailing Address Fletcher Alla Health Care Land Street (Office Name)

111 Colchester Aug 4th Floor Acc Monthern (Street)

(Street)

(City/State) (Zip Code) (Telephone Number) Woman's Health Care Struke Vermont License #: 042 - 000 9221 Hospital(s) where you have privileges: Hospital(s) Location Specialty List all physician's assistants names and addresses you currently supervise: CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Hephanic Sahi , P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted. I further certify that I have read the statutes and Board rules governing physician assistants. (Date)

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed. (Middle) Mailing Address Fletcher Alla Health Care Woman's Health Care Ser.

(Office Name)

(Office Name)

(Street)

(Street)

(City/State)

(Zip Code)

(Telephone Number) Woman's Health Care Server Vermont License #: <u>042-00/12</u>05 Hospital(s) where you have privileges: Hospital(s) Location Specialty List all physician's assistants names and addresses you currently supervise: CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Stephan: Sahl , P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted. I further certify that, I have read the statutes and Board rules governing physician assistants. (Signature of Secondary Supervising Physician)

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Hi Tracy,

Here are some additional signatures for my license (Stephanie Stahl, # 055-0030719).

I still have 6 others to get, and will send them to you as soon as I have them.

Included in this batch are: Elizabeth Bonney Paula Miner Elisabeth Wegner Stephen Brown Jill Jertson John Gallagher Jane Lowell

Thanks! Please call me (page through PAS at Stephanie Stahl

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I further certify that I have	read the statutes as	nd Board rules govern	ing physiciar	assistants.	
/2- /5 · (Date)	09		The second section of	Secretary Secret	
(Date)		(Signature of Sec	ondary Super	vising Physician)	

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List all physician's	assistants names	and addresse:	s you currently su	ipervise:	
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(Date)		(Signature	of Secondary Superv	vising Physician)	

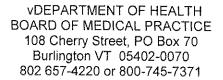
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further certify that I have (Date)		nd Board rules go	All I	n assistants.	
(Date)		(Signature of	Secondary Super	vising Physician)	

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List all physician's assistants names and a	duresses you currently supervise:	
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	(Last)	(First))	(Middle)	
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South Bi	ullington	(Street) VI OS403 Code)	®	802-862	-73]8
			(Telephone	Number)	
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$2 + ep V(x) \cdot e$ consulted by the afore to this application, do	said Physician Assistant. I fi	Chapter 31, I shall be legally rewards when the primary supervising arther certify that the protocolits of my practice and that in a seen posted.	g physician is u outlining the s	mavailable and only wo	hen hed
I further certify that I	have read the statutes and Bo	ard rules governing physician	assistants.		
\2-2\-n (Date)	P.	Signature of Secondary Superv	<u> </u>	n)	





2010 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION

PART I

Certificat	te #055-0030719	PARII	
1. Name:	: Stephanie Beth Sta	hl PA	
2. Other		der which you were certified or licensed in Vermont and elsewhere:	
 Work / Home 		Fletcher Allen Health Care 111 Colchester An, 44 Floor ACC Mein Pavillion Burlingram VT 05401	
City, Stat	e Zin Code:		
Please of	(This	mailing address: □ Home	Control of the Contro
6. Daytim	ne Telephone Numbe	er: Area Code:	
7. Date o	f Birth:		
8. Place	of Birth:		
9. Certific	cation Examination T	aken – (Check box and enter date of examination):	
¥	((<u>04 /22 / 09</u>)	NCCPA	
	(/)	State Examination-Identify state:	
Ε	(/)	Other Examination specify:	
10. Basis	for Vermont Certifica	ation – (Check box):	
	/ II 1 1/ mm 1		

11. Do you have hospital privileges in Vermont?
Hospital Name(s) and Location(s): Fletcher Allon Heelth Core III Cokchester Duc Burlington VT 05401
12. In what year did you start working as a physician assistant in Vermont?
13. Were you in active clinical practice in Vermont during the past 12 months? □ Yes □ No
14. Other states where you now hold an active certification or license to practice:
15. States where you previously were certified or licensed to practice:
16. Specialty: Warman's Machile DEA Number: MS1057408
17. Name and office address of current EMPLOYER:
Name Address
Fletcher Allan Health Core 111 Colchaster Du. Burlinston VT 05401
18. Please list (use additional sheet if necessary) name(s) and address(es) of physicians who currently serve as your PRIMARY and SECONDARY SUPERVISING PHYSICIAN(S).
Primary Supervising Physician(s):
Name Address Cheurs Wars MO III Calchoto Duc Burligton VT 05400
Secondary Supervising Physician(s):
Name Address
19. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current scope of practice for your practice setting, paying attention to any additions or deletions in duties and procedures. Please review, date and sign your scope of practice and have your PRIMARY SUPERVISING PHYSICIAN sign it as well. Attach a copy of your signed scope of practice to this application.
a. Has there been a change in your scope of practice which has not been reviewed by the Board? ☐ Yes ☒ No
20. Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a

Physician Assistant within the past twelve months.

- 21. Continuing Medical Education (CME) requirements:
 - a. NCCPA certified Physician Assistant: Attach proof of current NCCPA certification; this will serve as adequate proof of CME completion.
 - b. For all others, an explanation of requirements and a CME Record form must be completed.
- 22. Primary Supervising Physician and Second Supervisory Physician forms are provided. They must be completed and returned with this application.

PART II

"Yes" answers to Questions 23 - 47 require an explanation on Form A.

- 23. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?

 □ yes □
- 24. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?

□ yes 匀≼no

25. Have you ever voluntarily suspended, surrendered or resigned a certificate to practice medicine or any other healing art in lieu of disciplinary action or any other reason?

□ yes `ছ no

26. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

□ yes ˈ뭃ɪno

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

□ yes ⁄ 🖳 no

28. Have you ever discontinued your education, training, or practice for a period of more than three months?

□ yes 🥱 no

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

□ yes ˈ⊠⊆no

30. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?

□ yes 🕱 no

31. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?

□ yes þ≼no

32. Do you currently or have you ever prescribed any prescription medication over the internet? This does not include prescribing you would do using electronic medical records in your practice.

□ yes ˈ≰no

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

PART III

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

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

- 34. To your knowledge, are you the subject of an investigation by any other licensing board under which you have not been charged as of the date of this application?
- 35. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged?

The following definitions are provided to assist you in answering questions 36 through 38.

"Ability to practice medicine" - This term includes:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and 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 The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

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

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

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

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

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

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

37. 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?

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive Vermont Department of Health - Board of Medical Practice - 2010-2012 Physician Assistant Certification Renewal

ongoing treatment (with or without medication) or have participated or do participate in a monitoring program. 38. Are you currently engaged in the illegal use of controlled substances? In explaining a "Yes" answer on Form A, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine. IMPORTANT Since 1999, Board fees have been used to create and maintain the Vermont Practitioners Health Program, a confidential program for the identification, treatment and rehabilitation of practitioners, including physician assistants, affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line). Part IV - Statutory Profile Questions The following questions are required by Vermont law, 26 VSA § 1368, to update and maintain a data repository within the Department of Health and to make individual profiles on all health care professionals licensed, certified, or registered by the Department available to the public. Your practitioner profile is located at the following website http://healthvermont.gov/hc/med_board/profile_search.aspx_ Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 38 through 43 have changed since your last application. We cannot process your application without them. 39. Criminal Convictions [See 26 VSA § 1368(a)(1)] *Check here if none Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past 10 years Please provide complete copies of documentation for each matter. (Conviction Date) (Court) (City/State) (Crime) 40. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)] Please provide a description of all charges to which you pleaded "noto contendere" ("I will not contest it")

(Court)

(Conviction Date)

or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction. Please provide complete copies of documentation for each matter.

(City/State)

(Charge)

41.	Ve	rmont Boa	rd of Me	dical Practic	e Matters	[See 2	26 VSA § 13	68(a)(3)]	Chec	k here if none	
		Please pr Board of appealed	Medical	description of Practice (inc	of all forma cluding stip	al char oulation	ges served, ns), and fina	findings, co I disposition	nclusions, a n of such ma	nd orders of the tters by the cou	: rts, if
		(Date)				(Fina	l Disposition	ı - Summan	/)		······
42.		ensing or			y Matters i	n Othe	er States [Se	ee 26 VSA	§ 1368(a)(4)]	
		states, the	e finding:	s, conclusior	ns, and or	ders of	such author	rities, and fi	nal dispositio	on authorities of on of such matte umentation for	ers by
(Da	ate o	f Final Dis	position)	(Licensi	ing or Cer	tificatio	on Authority)	(Court)	(City/State)	(Nature of Char	ge)
43.	Re	striction of	Hospita	l Privileges	[See 26 V	'SA § 1	368(a)(5)]	≫c	heck here if	none	
		Revocation	n/Involu	ntary Restric	ctions						
		were related of the official o	ed to co the hosp	mpetence oi	r characte cedural du	r and w e proce	vere issued ess (opportu	by the hosp inity for hea	ital's govern	ospital privileges ing body or any o orded to you. Pl	other
		(Date)		(Hospital)	(Sta	te) ((Nature of R	estriction)	(Reason fo	or Restriction)	
		B. C	ther Res	strictions	` _P Chec	k here	if none				
		restriction	of privile ence or	ges at a hos	pital taker	ı in lieu	of, or in set	tlement of, a	a pending dis	ff membership c sciplinary case re documentatio	elated
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		(Nature o	f Action)	-	□ In lie	41	(Action) □ In settl	lement			
		(Reason f	or Action	n)		·u	m m sem	CHICH			
							10 00 \	SA § 1368(;	\(\alpha\)		

Check here if none

Α.

<u>Judgments</u>

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

None reported

		• • • • • • • • • • • • • • • • • • • •				
		□ Judgment	☐ Arbitration			
		(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Against You)
		□ Judgment	☐ Arbitration			
		(Date)	(Court)	(State)	(Nature of Case)	(Amount Assessed Against You)
	B.	Settlements	≻ Check here	e if none		
		within the past complaining pa	10 years (10 yearty if not listed	ears from p below. Ple	payment date) in wh ase provide comp	alpractice claims against you ich a payment was awarded to a lete copies of documentation, e complaint for each matter.
		None reporte	d			
		(Date)	(Court)	(State)	(A	mount of Settlement Against You)
	,	(Date)	(Court)	(State)	(A	mount of Settlement Against You)
15.	Years of P	<u>Practice</u> [See 26	VSA § 1368(a)	(10)] 20	04	
	What mor	nth and year did	you start practi	cing as a F	hysician Assistant?	01/2004
16.	you re gran	nting permission	to have this inf	ormation p	osted on the web. (\bar{r})	#46 is optional. By answering, This form follows the statutory estions may overlap.)
	A.	Appointments				
		Please provide faculties.	information ab	out your a	opointments to med	ical school or professional school
		University of	Vermont			
		Burlington, V	т			
		Clinical Instru	ctor			

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ZU	u	5

47.

	2005							
	(School)	(City)	(State)	(Nature of Appointment)	From (year) To (year)			
	(School)	(City)	(State)	(Nature of Appointment)	From (year) To (year)			
B.	Teaching							
	Please pro education	ovide informati within the pas	on regardi t 10 years.	ng your responsibility for tead	ching graduate medical			
	University	y of Vermont						
	Burlingto	n, VT		,				
	Preceptin	g Medical Stu	ıdents					
	2005							
(Schoo	ol/Institution)	(City)	(Sta	ate) (Nature of Teaching)	From (year) To (year)			
Publica	Publications [See 26 VSA § 1368(a)(13)]							
Note: Answering #47 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.								
None r	reported							
(Title)		***************************************	(F	Publication)	(Year)			

(Title)	(Publication)	(Year)
(Title)	(Publication)	(Year)

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

> Note: Answering #48 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.

None reported

(Activities or Awards)

49. Practice Setting [See 26 VSA § 1368(a)(15)]

What is the location of your primary practice setting?

Burlington, VT

Town/City, State

50. Translating Services [See 26 VSA § 1368(a)(16)]
Please identify any translating services available at your primary practice location. Are any translating services available at your primary practice location?
If yes, please describe the translating services available: None
We have a teleconformer source available to obtain translators for any language
51. Medicaid/New Patients [See 26 VSA § 1368(a)(17)]
A. <u>Medicaid participation</u> Do you participate in the Medicaid program? ✓ Yes □ No
B. <u>New Medicaid Patients</u> Are you currently accepting new Medicaid patients?
Part V
I hereby affirm that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.
Date: 11/20/2009 Stylen Ital
Applicant's Signature

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

State of Vermont Department of Health Board of Medical Practice

Statement of Good Standing

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

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

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

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

- (1) 60 days or fewer have elapsed since the date a judgment was issued; or
- (2) the person is in compliance with a repayment plan approved by the judiciary.

Signatur	re: Styl	_ Du	
T .	100000		
Date:	12/1/68		

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, **UNEMPLOYMENT COMPENSATION CONTRIBUTIONS**

You must answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under

support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overduor 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 play 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)	ie; an
1. You must check 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.	er V
I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".	
Regarding Taxes Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business 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 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, the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)	all or
2. You must check 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 plat 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).	7
or I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application a I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship". Regarding Unemployment Compensation Contributions	nd
Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions or payment in lieu of contributions or payment of contributions or payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.)
3. You <u>must</u> check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contributions:	
I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a \$10, 000.00 fine or both.)	
I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.	at
or I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.	
Social Security # Date of Birth	
* 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 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.	oy ∍d
STATEMENT OF APPLICANT	

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

Date_ \\/3>/२००२ Signature of Applicant

MD	Practice	Signed
Cheung Wong	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	1,,,,,,,,,,
Elizabeth Bonney	FAHC WHCS, 4th Floor ACC. 111 Colchester Ave. Burlinton VT 05401	-
Robert Hayward	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	-
Elisabeth Wegner	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Roger Young	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	Same
Eleanor Capeless	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	Same
David Jones	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	same.
Marjorie Meyer	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	Larendon .
Mark Phillippe	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	i navorana de la companya de la comp
John Brumsted	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	Lander
Peter Casson	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	in the second
Christine Murray	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Daniel Riddick	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	Bertan
Jule LaCombe	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Emmanuel Soultanakis	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	-
Stephen Brown	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Tracy Maurer	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	
Ira Bernstein	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	L
Peter Cherouny	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	isomorphic
Kristen Wright	FAHC WHCS, 4th Floor ACC, 111 Colchester Ave. Burlinton VT 05401	2
Gamal Eltabbakh	Lake Champlain Gynecologic Oncology, 364 dorset Street. So Burlington, '	VT 05403
Kelley Clock		la constant
Anne Viselli	Vermont Urogynecology, 71 Knight lane, Suite 1. Williston, VT 05495	
Diane Charland	Vermont Urogynecology, 71 Knight lane, Suite 1. Williston, VT 05495	isonomic and a second
Patrick Clifford	Affiliates in OB Gyn, 96 Colchester Ave, Burlington VT 05401	2/
Dale LaCroix	Affiliates in OB Gyn, 96 Colchester Ave, Burlington VT 05401	jumin .
Kimberly Blake	Affiliates in OB Gyn, 96 Colchester Ave, Burlington VT 05401	
Greta Hanson	Affiliates in OB Gyn, 96 Colchester Ave, Burlington VT 05401	in the state of th
George Till	Champlain OB Gyn, 55 Main Street, Essex Junction VT 05452	
John Gallagher	Champlain OB Gyn, 55 Main Street, Essex Junction VT 05452	
Jill Jertson	Champlain OB Gyn, 55 Main Street, Essex Junction VT 05452	
Sally Stockwell	Champlain OB Gyn, 55 Main Street, Essex Junction VT 05452	in the same of the
Kara Flaherty	Champlain OB Gyn, 55 Main Street, Essex Junction VT 05452	
Paula Miner	Champlain OB Gyn, 55 Main Street, Essex Junction VT 05452	İ

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Jennie Lowell	Maitri, 96 Colchester Ave, Burlington VT 05401	
Julie Wade	Maitri, 96 Colchester Ave, Burlington VT 05401	
Chery Gibson	Vt Womens Choice, 23 Mansfield Ave, Burlington VT 05401	i comment
Kym Boyman	Vt Womens Choice, 23 Mansfield Ave, Burlington VT 05401	landra .
Susan Smith	Vt Womens Choice, 23 Mansfield Ave, Burlington VT 05401	2º de la companya de
Nancy Fisher		

PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Inco	mplete applica	tions will be returned. A	ttach additional sh	eets as needed.
Name in full	Wohs	Chev		
	(Last)	(Last) (First)		(Middle)
Mailing Address	Fletche	- Alla Middle Con	yer Floor Acc (ne
	III Colchotor	- Alla Hoolly Core (Office Name	e)	
Gustin	ytan VT	(Street) 5546((Zip Code)	(603/	447-5110
(City/State	2)	(Zip Code)	(Telepho	one Number)
Vermont License	<u> 1900 - CPO :#</u>	<u>(8</u>		
Hospital(s) where Fixtche AIN H		lleges: Hosp	ital(s) Location	Specialty Gynewlys Oncol
What arrangemen کلومانی مرده این کرده	ts have you ma	de for supervision when y	you are not availab	ole or out of town:
		FICATE OF SUPERVIS		
the scope of practice,	attached to this a	n 26 VSA, Chapter 31, I shall b _, P.A. while under my superv oplication, does not exceed the ssistant is used, in accordance	ision. I further certify normal limits of my p	that the protocol outlining ractice. I further certify t
I further certify that I	have read the stat	utes and Board rules governing	physician assistants.	
\ヲ <u>) コ / し</u> ९ (Date)			f Supervising Physicia	
(Date)				
		Co-signature of PA:	The Day	4
Note: A PA who pres	cribes controlled	drugs must obtain an ID numbe	er from DEA PA's D	FA Number

		ns will be returned. A	-	ts as needed.	
Name in full	Giban	Chery (Firs	(
Villettin	(Last)	(Firs	(Middle)		
Mailing Addres	s Ves	mout Woman's Ch.	معادي فر		
	23 Monsfield	(Office Nam	ie)		
Burt	linsten VT	(Office Name (Office Name (Street) (Street) (Zip Code)			
(City/Sta	ate)	(Zip Code) (Telephon		e Number)	
Vermont Licens					
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List all physic	 Johanna Haus Anne Hildreth, Cate Nicholas, Katja Von Sitas 	urrent VT PA's: 90 Washington Street er 23 Mansfield Ave, B 6 Roberts North, Ruth 23 Mansfield Ave, Bur s, 80 Fairfield Street, S Mansfield Ave, Burl.	Burl, VT 05401 and, VT 05701 d.		
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12/8/09 (Date)	· · · · · · · · · · · · · · · · · · ·	(Signature of Second	dary Supervising Physicia	an)	

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Name in full	Barmon	- Kym (First)		Margaret	
	(Last)	(Firs	t)	(Middle)	
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***************************************	23 Monsfield 1	\u e_			
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	e#: <u>042-00</u> 1				
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**	 Amy Borgman, 9 Johanna Hauser Anne Hildreth, 6 Cate Nicholas, 23 Katja Von Sitas, 8 Janet Young, Ma 	23 Mansfield Ave, Roberts North, Rut 3 Mansfield Ave, Bu 80 Fairfield Street, nsfield Ave, Burl.	Burl, VT 05401 tland, VT 05701 trl. St. Albans, VT 054	478	
	CERTIFICATE OF S	SECONDARY SU	PERVISING PHY	YSICIAN	
consulted by the aform this application, described 1741, the us	resaid Physician Assistant	only when the primary I further certify that the limits of my practice and been posted.	supervising physician he protocol outlining t and that in accordance	for all medical activities of is unavailable and only when the scope of practice, attached with 26 VSA, Chapter 31,	
12/7/ (Date)			dary Supervising Phys		

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Name in full	Smill	Ş	<u> </u>		
	(Last)	(F	irst)	- 1994	(Middle)
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Burlins	ton VT ((Street) 2540/			
(City/State)	(Zip Code)	(Te	elephone Nu	ımber)
Vermont License #:	•				
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I further certify that I have 12 9 09 (Date)	e read the statutes and		ning physician assis	h 0/	hut

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	(Last)		(First)		(Middle)
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Burlinston	V7 D	(Street)	4021 84.	
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I hereby certify that, in acceptable of the strange of the strange of the strange of a section 1741, the use of a	Physician Assistant. of exceed the normal l	nly when the p I further certif imits of my pra	orimary supervising that the protocol actice and that in	ng physician is una of outlining the sco	vailable and only when pe of practice, attached
I further certify that I have		Board rules go	verning physician		
12/7 (Sq (Date)	THE PROPERTY OF THE PROPERTY O	(Signature of		rvising Physician)	

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Name in full	Bernstein		Lia	·	
Name in full	(Last)	· · · · · · · · · · · · · · · · · · ·	(First)		(Middle)
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Metcher	Allen b	tealth (are k	Burlington	OB/64N
List all physician's as	sistants names a	nd addresses	you currently s	upervise:	,
<u></u> Stepha	nie Stahl,	PA-			
CERT	TIFICATE OF S	SECONDAR	Y SUPERVIS	SING PHYSIC	IAN
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Burlinston	77 <u>D</u> . (Z	(Street) 5401	-	4021 84-	1- 14W
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List all physician's ass	sistants names and	addresses you			
CERT	IFICATE OF SE	CONDARY S	SUPERVIS	ING PHYSICI	AN
I hereby certify that, in accommod to the symbol of the sy	Physician Assistant. I	ly when the prim further certify th	ary supervising	g physician is unav	vailable and only when
to this application, does not Section 1741, the use of a p	exceed the normal lin	nits of my practic	e and that in a	ccordance with 26	VSA, Chapter 31,
I further certify that I have t	ead the statutes and B	oard rules govern	ning physician	assistants.	,
12/1/09		I L		Clarke	
(Date)		(Signature of Sec	ondary Superv	vising Physician)	***************************************

Please print. Incomp	lete applications	will be returned.	Attach addit	tional sheets a	s needed.
Name in full	Ni Ti	G	ofse		
Name in full					
Mailing Address	Fletche Alla	Meeth Core-	Woma's 1	Mooth Con	Sovice
Mailing Address	Colchala Pur	(Office Na	ıme)		
Burlinston	77	(Street)		HOD1 847	- 1405
(City/State)	(2	Zip Code)	((Telephone Nu	ımber)
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Hospital(s) where you	i have privileges: Allean Hal	Ho calth C	spital(s) Loc	ation Burlington	Specialty <u>VT 08</u> [64n
List all physician's as	sistants names an	d addresses you	currently sup	ervise:	,
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further certify that I have	read the statutes and	Board rules govern	ing physician a	ssistants.	
12/7/09 (Date)	PARAMETERS	(Signature of Second	191 Z	11/16	<i>[</i>
(Date)		(Signature of Second	ondary Supervi	sing Physician)	1

Please print. Incom	plete applications will be re	eturned. Attach ad	ditional sheets a	is needed.
Name in full	Zons	Dovid		
	(Last)	(First)		(Middle)
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further certify that I hav	e read the statutes and Board ru	les governing physicia	n assistants.	
12/7/29			And the Control of th	
(Date)	(Signati	ure of Secondary Supe	rvising Physician)	THE STATE OF THE S

Please print. Incomp	plete applicat	tions will be re	eturned	. Attach add	ditional sheets a	is needed.
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Burlinston	77 (2	(Street) 5540 (H021 81	17-1405
(City/State)	(2	Zip Code)	(Telephone	The state of the s
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PHYSICIAN ASSISTANT SCOPE OF PRACTICE

WOMEN'S HEALTH CARE SERVICES FLETCHER ALLEN HEALTH CARE 111 COLCHESTER AVENUE BURLINGTON, VT 05401

a) NARRATIVE

Fletcher Allen Health Care, Women's Health Care Services is composed of a team of professionals who provide the full scope of OB/GYN services. Physicians, certified nurse midwives, nurse practitioners, and a physician assistant work in collaborative arrangement. The physician assistant provides Gyn and OB care to our patient population, as do our existing providers. Resident physicians and students rotate through the Women's Health Care Services during their training.

Physician Assistants practice under the supervision of attending OB/Gyn physicians. The primary role of the PA is to provide ongoing care for female patients as determined by the PA's training and experience and by the services provided by the supervising physicians. In addition, PA's are involved in both didactic and clinical training of students.

b)SUPERVISION

Supervision of the PA is provided by the primary supervising physicians or one of the secondary supervising physicians when caring for their patients. One of the primary or secondary supervising physicians is available 24 hours a day, 7 days a week. Supervision may include the following mechanisms:

- 1) direct supervision by an attending physician
- 2) consultation with an attending physician in person or by phone
- 3) retrospective chart review
- 4) participation in Women's Health Services quality assurance meetings

c) SITES OF PRACTICE

Fletcher Allen Health Care, Women's Health Care Services MCHV Campus, 111 Colchester Avenue, Burlington, VT ACC Campus, 4th floor, Main Pavilion, Burlington, VT UHC at Blair Park, Williston, VT

d) TASKS

The following list is intended to express a sense of involvement in medical care provision and is not intended to be all inclusive or limiting, except as specifically excluded by the Board of Medical Practice, health care facility, or law. At no time will the physician assistant function in a capacity that exceeds the normal scope of practice of the supervising physicians. The supervising physician may

delegate ay and all tasks that by reason of training and experience, the PA can be expected to perform.

- 1. Elicit patient histories
- 2. Perform physical examinations
- 3. Order laboratory test, radiographic imaging, and other diagnostic testing.
- 4. Write nursing and other therapeutic orders to be carried out in accordance with hospital policy
- 5. Interpret diagnostic and screening studies
- 6. Provide advice over the telephone
- 7. Provide education and counseling of patients and arrange for follow up care and referrals
- 8. Insertion of IUDs
- 9. Perform routine gynecologic and obstetric tests, including, but not limited to pap smears, endometrial biopsies, vulvar biopsies
- 10. Insert IV lines, catheters, obtain venous and arterial blood samples, and nasogastric tubes
- 11. Administer or dispense medication in accordance with hospital policy
- 12. Assist in gynecologic surgeries
- 13. Initiate resuscitative measures in accordance with ACLS standards and hospital policy
- 14. Write prescriptions for medications, including controlled drugs and devices in accordance with Vermont law and DEA regulations.

e) PRESCRIPTIVE PRACTICE

The PA named in this document is authorized to prescribe medications, including controlled drugs, in accordance with this scope of practice as approved by the Vermont Board of Medical Practice. The PA's DEA number is MS 1057428

Duh Itel	19/17/09
Signature of Physician Assistant	Date
A Company of the comp	12/27/09
Signature of Supervising Physician	Date 1

The University of Vermont

DIVISION OF GYNECOLOGIC ONCOLOGY AMBULATORY CARE CENTER 111 COLCHESTER AVENUE MAIN PAVILION, LEVEL 4 BURLINGTON, VT 05401 PH: (802) 847-5110; FAX: (802) 847-0496



December 1, 2009

To Whom It May Concern:

Please allow this letter to serve as verification that Stephanie Stahl, P.A.-C has been employed full time as a physician assistant with our practice since February 14, 2005. She works as a physician assistant with our inpatient gynecology and gynecologic oncology service, and also sees patients in our ambulatory care clinic for routine gynecologic care.

Please feel free to contact me with any questions.

Sincerely

Cheung Wong, My

Director, Gynecology

Fletcher Allen Health Care

111 Colchester Avenue

Burlington, VT 05401

802-847-5110

Certification Status Report

NCCPA nccpa@nccpa.net • (678) 417-8100 • 12000 Findley Road Suite 200 • Duluth, GA 3009

Stephanie Stahl is currently certified by NCCPA and holds identification no.1059860.

Identification no. 1059860 will remain valid until 12/31/2011. This PA was initially certified on 9/19/2003. However, this PA may or may not have been continuously certified during this timeframe.

Copyright © 2009 NCCPA. All rights reserved.

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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DEC 16 2009

Renewal - 055.0030719 Page 1 of 12

Renewal - 055.0030719

Name	Stephanie Beth Stahl	
Credential	055.0030719	
Fee Details		
Renewal	\$170.00	
	\$170.00	

Renewal Introduction

VERMONT DEPARTMENT OF HEALTH BOARD OF MEDICAL PRACTICE PO BOX 70, Burlington, VT 05402 Phone: 802-657-4223 Fax:802-657-4227 Toll: 800-745-7371 www.healthvermont.gov

Physician Assistant License Renewal

This application includes your Physician Assistant License Renewal Application. Please follow the instructions below and submit the completed application with uploaded documentation and credit card payment. If you have any questions or need additional information do not hesitate to contact us at 802-657-4220, 800-745-7371 or medicalboard@state.vt.us. Your licensure will lapse if we have not received your completed application and fee by the due date.

INSTRUCTIONS

You may download all forms that must be submitted to complete this application here.

- enter, correct, or update all information
- answer all questions completely, even if you believe the information is already on file with the Board
- provide explanations to "yes" answers in Parts II IV
- do not delegate this important task to any other person. False statements on this form may be grounds for charges of unprofessional conduct

Be sure to complete, submit or upload:

• completed application and appropriate attachments, e.g. Primary and Secondary Supervising Physician Applications, CME Form, NCCPA Certificate, Scope of Practice, etc.

Please send all appropriate documentation to the Board and submit the completed application, attachments and fee no later than January 15 to facilitate timely processing and avoid an interruption in your ability to practice because of a lapsed license.

Please Note:

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

1. Last Name:

Stahl

2. First Name:

Stephanie

3. Middle Name:

Beth

4. All other names used:

Previous Name	From Month	From Year	To Month	To Year	Reason for Change
			September	2012	

Renewal - 055.0030719

5. Enter your MAILING ADDRESS information:

Attention

Street

City

State

State

Zip

Country

United
States

E-mail Address

Telephone

Alternate Phone (e.g. Pager)

6. Enter your PUBLIC ACCESS address information:

Attention FAHC-Womens Health Care Services

Street 111 Colchester Avenue 4th Floor

City BURLINGTON State VT Zip 05401

Country United States
Telephone (802) 878-7651

E-mail Address

Alternate Phone (e.g. Pager)

7. Date of Birth:



8. Birth City:



9. Birth State/Province:



10. Birth Country: United States

- 11. Select the certification examination taken (verification must be sent directly to this office from the Examining Agency):
 University Trained NCCPA Examination
- 12. Date NCCPA Examination was taken (if applicable): 04/22/2009
- 13. Date VT Apprenticeship Examination was taken (if applicable):
- 14. Basis for Vermont Certification: University Trained
- 15. Do you have hospital privileges in Vermont? Yes
- 16. List all hospitals where you have, or previously have had, privileges:

Facility Name	State	Start Date	
Fletcher Allen (FAHC, MCHV)	Vermont	01/01/2005	

- 17. In what year did you start working as a physician assistant in Vermont?
- 18. Were you in active clinical practice in the past 12 months?
 Yes

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19. Other states where you either now hold an active certification or license or previously were certified or licensed to practice:

State	Profession	License Number	Issue Date	Expiration Date	Status
New York	PA	015404-1		11/30/2014	Active

20. Specialty:

Women's Health/gynecologic oncology

21. DEA Number: MS 1057428

22. Enter information for all Primary and Secondary Supervising Physicians. If you are to be supervised by a Doctor of Osteopathic Medicine please provide your response(s) in the next question. Enter ONLY those supervisor(s) who ARE NOT Doctor(s) of Osteopathic Medicine here.

Supervisor	Relationship Type	Practice Location
042.0009968 : WONG CHEUNG	Primary Supervising Professional	FAHC - Womens Health Care Services
042.0010080 : CHARLAND DIANE	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0010133 : LACROIX DALE	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0009874 : MURRAY CHRISTINE	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0007565 : BERNSTEIN IRA	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0008805 : BLAKE KIMBERLY	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0010491 : BONNEY ELIZABETH	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0011186 : BROWN STEPHEN	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0007101 : BRUMSTED JOHN	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0006511 : CAPELESS ELEANOR	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0008079 : CARLSON NANCY	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0012266 : CARRACINO MARIA	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0009989 : CASSON PETER	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0007412 : CLIFFORD PATRICK	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0012288 : EVERETT ELISE	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0007040 : GALLAGHER JOHN	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0007465 : GIBSON CHERYL	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0012103 : HAMMER ERICA	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0011559 : HANSON GRETA	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0006592 : HAYWARD ROBERT	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0010721 : LOWELL JANE	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0010177 : MAURER TRACEY	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0007765 : MEYER MARJORIE	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0011466 : MINER PAULA	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0012157 : NIELSEN BRIAN	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0011596 : PHILLIPS JULIE	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0012086 : RAJ RENJU	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0005990 : SMITH SUSAN	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0007744 : TILL GEORGE	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0011126 : WADE JULIE	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0009221 : WEGNER ELISABETH	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0010570 : FLAHERTY KARA	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0008739 : VISELLI ANNE	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0010606 : THIBAULT AMY	Secondary Supervising Professional	FAHC - Womens Health Care Services
042.0010174 : JONES DAVID	Secondary Supervising Professional	FAHC- Womens Health Care Services
042.0010597 : BOYMAN KYM	Secondary Supervising Professional	FAHC Womens Health Care Services

23. If you are to be supervised by a Doctor of Osteopathic Medicine, enter the information for those Primary and Secondary Supervising Physicians. Enter **ONLY** those supervisors who **ARE** Doctor(s) of Osteopathic Medicine here.

DO Supervisor Relationship Type Practice Location	200	-	.
	DO Supervisor	Relationship Type	Practice Location

24. Has there been a change in your scope of practice which has not been reviewed by the Board? No

Continuing Medical Education (CME) Requirements

25. NCCPA certified Physician Assistant: Upload proof of current NCCPA certification; this will serve as adequate proof of CME completion.

NCCPA certification verification.pdf

26. For all others, an explanation of requirements and a CME Record form must be completed and uploaded here.

Primary Supervising Physician and Second Supervisory Physician forms are available here. They must be completed and returned to the Board to complete this application.

Renewal Part II

ANY "	YES" RESPONSE	TO THE QUESTION	IS RELOW MUST	r re fill i y fypi	AINFD

27. Have you ever applied for and been denied a license or certificate to practice medicine or any other healing art? No
28. State:
29. Year:
30. Circumstances under which you applied and were denied a certificate to practice medicine or any other healing art:
31. Denied certificate to practice medicine or any other healing art - Upload documents
32. Have you ever withdrawn an application for a license or certificate to practice medicine or any other healing art? No
33. State:
34. Year:
35. Circumstances under which license or certificate was withdrawn, denied, revoked, not renewed, or otherwise terminated:
36. Withdrawal or denial of license or certificate - Upload documents:
37. 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
38. State:
39. Year:
40. Circumstances:
41. Voluntary surrendered or resigned a license or certificate to practice medicine or any healing art - Upload documents:
42. 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
43. Name of organization involved:
44. Date:
45. Duration:
46. Action Taken (add all that apply):
47. Circumstances:
48. Disciplinary charges or actions - Upload documents:
49. Have you ever been denied the privilege of taking an examination before any state medical examining board? No
50. State:
51. Circumstances under which examination privileges denied:
52. Denial of examination privileges - Upload documents:
53. Have you ever discontinued your education, training, or clinical practice for a period of more than three (3) months NOT including premedical education? No
54. If yes, please explain and include the dates over which your education, training, or clinical practice was discontinued:
55. Discontinued Education, Training, or Clinical Practice - Upload documents:
56. Have you ever been dismissed or suspended from, or asked to leave a training program before completion? No
57. Training program(s):
58. Location of program(s):
59. Year:
60. Circumstances:
61. 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
62. Institution involved:
63. Location:

64. Year:
65. Circumstances:
66. Affecting health care institution staff privileges, employment or appointment - Upload documents:
67. 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
68. Name of organization involved:
69. Type of restriction:
70. Date:
71. Circumstances:
72. Privilege to prescribe controlled substances - Upload documents:
73. 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
74. Please provide a general description of your practice of internet prescribing:
75. Are you presently, or have you ever been, a defendant in a criminal proceeding? No
76. Court:
77. City and state:
78. Charge:
79. Description:
80. Status:

Renewal 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.

81. 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?



82. Licensing or certification board:

83. Date:
84. Location of Licensing Board:
85. Circumstances:
86. Investigation by other licensing or certification board - proceeding - Upload documents
87. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged?
88. Court:
89. City and state:
90. Charge:
91. Description:
92. Status:
93. Date:
94. Criminal Investigation - 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.

DEFINITIONS

In answering the following questions, please use these definitions:

"Ability to practice medicine" - This term includes:

- 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
- "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.
- 95. 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?



- 96. 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.
- 97. Please upload any documents you have that are relevant to this matter.
- 98. 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?



- 99. 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.
- 100. Please upload any documents you have that are relevant to this matter.
- 101. Are you currently engaged in the illegal use of controlled substances?



- 102. 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.
- 103. Please upload any documents you have that are relevant to this matter.

IMPORTANT

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

Renewal Part IV

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.

- 104. <u>Criminal Convictions</u> [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
- 105. 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

106. 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

107. 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

108. 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

109. 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

110. 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?

111. 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)]

112. Have your hospital privileges ever been revoked or involuntary restricted in relation to competence or character?

113.

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

114. 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

115.

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

116. <u>Medical Malpractice Court Judgments/Settlements</u> [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

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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

118.

<u>B. Settlements</u> 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.

119. Years of Practice

What year did you start practicing as a medical professional? 2004

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

Facility Name	City	State	Start Date	End Date
Fletcher Allen (FAHC, MCHV)	Burlington	Vermont	01/01/2005	

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.)

121

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
University of Vermont	Burlington	Vermont	Clinical Instructor	01/01/2005	

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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
University of Vermont	Burlington	Vermont	Precepting Medical Students	01/01/2005	

123. 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.

	B 1 11 41	
Title	Publication	Publication Date
11610	. 45.164.161.	i abilidation bato

124. 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				
Served as Secretary of the PA academy of Vermont, 2011-2014				

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

Practice Name	City		Primary Practice	Languages		Accepts New Medicaid Patients?
FAHC-Womens Health Care Services	BURLINGTON	Vermont	Yes		Yes	Yes

Statement of Good Standing

126

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

127. Date:

12/13/2013

Statement Regarding 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)

128. You <u>must</u> 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 <u>and payable and all returns have been filed</u>, 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)

129. You must select one of the two statements below regarding taxes:

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.

130. Social Security Number:



131. Date of Birth:



132. 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

133. Date:

12/13/2013

Workforce Survey

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**

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

Renewal Payment

135. 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