

September 18, 2000

Gailyn B. Thomas

To Whom It May Concern:

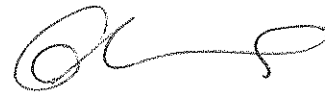
This letter is to notify you of my new addresses effective 10/15/00:

Home:

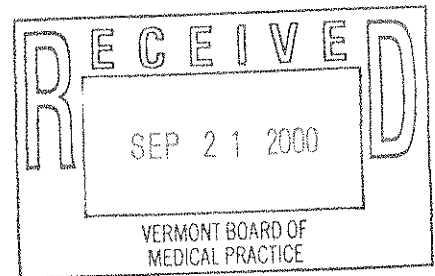
Work: Women's Choice Gynecological Associates
23 Mansfield Avenue
Burlington, VT 05401
Phone: (802) 863-9001
Fax: (802) 862-9637

Thank you for updating your files to reflect these changes.

Sincerely,

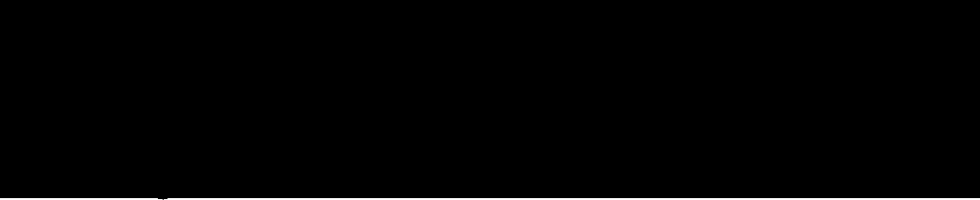


Gailyn B. Thomas, M.D.



STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
For Office Use Only - Medical Doctor Application Checklist
Physician Status Sheet, Page 1 of 2

Name of Applicant: Garlen Brooke Thomas

Address: 

Telephone:

Date Application Received: 7/31/2000


☒ US Graduate ☐ Canadian Graduate ☐ International Graduate

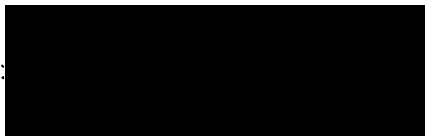
* (Unless noted, a copy of the original--and English translation, if applicable--is required to be submitted):

- 1) ☒ Fee of \$400
- 2) ☒ Completed "APPLICATION FOR LICENSE TO PRACTICE MEDICINE IN VERMONT"

☒ Photograph

*3) ☒ Notarized copy of birth certificate.

Date of Birth: 

Place of Birth: 

*4) ☒ Notarized copy of Medical School Diploma from:

Medical College of Penn. Date: 5/19/90

*5) ☒ Direct verification. "CERTIFICATE OF MEDICAL EDUCATION".

*6) ☒ Direct verification. "Certificate of Medical Licensure".

☒ Pennsylvania

☒ Delaware

*7) ☒ EXAMINATION SCORES: Direct Verification Examination Scores:

☐ USMLE* ☐ FLEX

☒ National Boards ☐ State Examination

* ☐ Number of times applicant has taken USMLE Step 3. Can be no more than 2.

Physician Status Sheet, Page 2 of 2

- *8) ☒ Notarized copy of American Specialty Board Certificate, if applicable.

OB/GYN (BC)

____ Internal verification of ABMS certificate using toll free number or ABMS Web Site

- *9) ☒ Direct verification of Postgraduate Training from an A.C.G.M.E. approved residency program. "VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION" must be completed by Program Director.

☒ Reading Hosp & Med. Cntr. DATES 7/90 - 6/94 ACGME _____
____ DATES _____ ACGME _____
____ DATES _____ ACGME _____

- 10) ☒ Three (3) completed Reference forms mailed directly to the Board by the Chief of Service and two other active physician staff members at the hospital where the applicant has a current or recent appointment. Program Director should be Substituted for Chief of Service for applicants who are applying for a license while still in residency training or have completed a residency within the last year.

☒ #1 Chief of Service Robert Haggerty
or _____ Program Director _____

☒ #2 Active Physician Staff Member Olesh Babiak

☒ #3 Active Physician Staff Member David Ginsburg

- 11) ☒ American Medical Association Profile Form.

- *12) ☒ ECFMG Certificate NA VERIFICATION OF FIFTH PATHWAY

- 13) ☒ National Practitioner Data Bank self query: applicant sends the original, unaltered response to the Board.

- 14) ☒ Completed Form A if applicant answered "Yes" in Section III

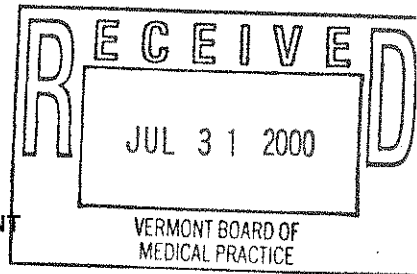
- 15) ☒ Applicant's Signature Required:

☒ Photograph in Section II;
☒ Tax and Child Support Statement - end of Section IV; and
☒ Form B: Release

- 16) _____ Federation Check: Internal Federation Disciplinary Check by computer

NOTE: FCVS Acceptance - The Board accepts certain documents (see * above)

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673



APPLICATION FOR LICENSE TO PRACTICE MEDICINE IN VERMONT
PHYSICIAN - MEDICAL DOCTOR - PAGE ONE OF SEVEN

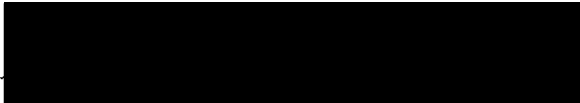
FEE: Enclose a check in the amount of \$400. made payable to the Vermont Board of Medical Practice.

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 III**.
- 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.

SECTION I

Name: Thomas Carolyn Brooke
(Last) (First) (Middle) (Former)

Mailing Address: 

Office Address: Suite 331 Amb Care Pavilion CCME
(Street)

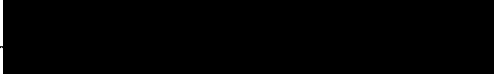
Upland PA 19013 610 872 6026
(City) (State) (Zip Code) (Phone)

Home Address: same as mailing address

City, State, Zip Code: _____

Daytime Telephone Number: Area Code: (_____) same as office

Date of Birth: Month: 

Place of Birth:  Sex: _____ Male ☒ Female

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
APPLICATION FOR LICENSURE - PHYSICIAN - MEDICAL DOCTOR, PAGE TWO OF SEVEN

SPECIALTY

Specialty: OBstetrics + Gynecology

Subspecialty: _____

American Specialty Board Certified? ☒ Yes ☐ No If yes, enclose a Notarized copy of Board Certificate.

Specialty?: OBstetrics + Gynecology Year Certified?: 1996

Subspecialty Certificate?: _____ Year Certified?: _____

NAME FOR CERTIFICATE - NAME CHANGES - OTHER NAMES LICENSED

Name as it should appear on your license certificate: Gailyn Brooke Thomas

Have you ever legally changed your name? ☐ Yes ☒ No
If Yes, enclose a certified copy of the legal document stating the change.

Other Name(s), if any, under which you were licensed elsewhere: _____

PREMEDICAL EDUCATION

Wesleyan University 1980-84 B.A.
(Name and location of Institution) (From/To) (Degree)

University of Pennsylvania 1985-86 College of
(Name and location of Institution) (From/To) (Degree) general studies

(Name and location of Institution) (From/To) (Degree)

MEDICAL EDUCATION-See also Certificate of Medical Education

Medical College of Pennsylvania 1986-90 M.D.
(Name and location of Institution) (From/To) (Degree)
now called MCP Hahnemann
Philadelphia PA

(Name and location of Institution) (From/To) (Degree)

(Name and location of Institution) (From/To) (Degree)

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
APPLICATION FOR LICENSURE - PHYSICIAN - MEDICAL DOCTOR, PAGE THREE OF SEVEN

TRAINING

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

Name	Address	From/To	Training
The Reading Hospital and Medical Center	West Reading PA	7/90 - 6/94	OB/GYN Residency

PRACTICE

Do you have hospital privileges? ☒ Yes ☐ No

List all hospitals where you have, or previously have had, staff privileges. Include name, address, and dates.

Name	Address	From/To	Specialty/Subspecialty
Crozer Chester Med Center	Upland PA 19013	1994-2000	OB/GYN
Taylor Hospital	Ridley Park PA 19078	1994-2000	OB/GYN
Riddle Memorial Hospital	Media, PA 19063	1994-2000	OB/GYN

OTHER LICENSES

Have you ever held a Vermont Limited Temporary License? ☐ Yes ☒ No
If Yes, License Number: _____

Do you hold, or have you ever held, a medical license in any other state? ☒ Yes ☐ No If yes, complete the section below and send a Certificate of Medical License to each state.

State	License Number	Date Issued	Status (Active or Inactive)
PA	MD048663L	1992	active
DE	CI 0004621	1997	inactive

EXAMINATIONS

USMLE OR FLEX EXAMINATION:

Have you ever taken the USMLE or FLEX examination? ☐ Yes ☒ No If yes, have a CERTIFIED COPY of your results forwarded to this office by the Federation of State Medical Boards (see enclosed card).

NATIONAL BOARDS: Have you ever taken the National Boards? ☒ Yes ☐ No If yes, have a CERTIFIED COPY of your results forwarded to this office by the National Board of Medical Examiners (see enclosed card.)

STATE EXAMINATION: Have you ever taken a State Medical Board Examination? ☐ Yes ☒ No If yes, make sure that the scores are included on the Certificate of Medical Licensure to be sent to that Board (see enclosed Certificate of Medical Licensure).

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
APPLICATION FOR LICENSURE - PHYSICIAN - MEDICAL DOCTOR, PAGE FOUR OF SEVEN

INTERVIEW

In which part of Vermont would you prefer to be interviewed? (Northern: Burlington; Southern: Springfield or Rutland; Central: Montpelier): Northern

When are you scheduled to begin work in Vermont? 11/1/00

What has been your physical residence (City, State) in the past ten years?: Wallingford, PA

INTERNATIONAL MEDICAL GRADUATES

ECFMG Standard Certificate Number: _____ Date Issued: _____

Direct Verification of your ECFMG CERTIFICATE must accompany this application. (See enclosed request form)

Are you a graduate of a fifth pathway program? ☐ Yes ☐ No

If yes, direct verification of your fifth pathway certificate must accompany this application.

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.



STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
APPLICATION FOR LICENSURE - PHYSICIAN - MEDICAL DOCTOR, 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 license to practice medicine or any healing art? ☐ Yes ☒ No
2. Have you ever withdrawn an application for a license to practice medicine or any healing art? ☐ Yes ☒ No
3. Have you ever voluntarily surrendered or resigned a license to practice medicine or any healing art in lieu of disciplinary action? ☐ Yes ☒ No
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 medical association (international, national, state or local)? ☐ Yes ☒ No
5. To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application? ☐ Yes ☒ No
6. Have you ever been denied the privilege of taking an examination before any State Medical Examining Board? ☐ Yes ☒ No
7. Have you ever discontinued your education, training, or practice for a period of more than three months? ☐ Yes ☒ No
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 lieu of disciplinary action; or resigned from a medical staff after a complaint or peer review action has been initiated against you? ☐ Yes ☒ No
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? ☐ Yes ☒ No
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? ☐ Yes ☒ No
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)? ☐ Yes ☒ No
13. Have you ever been turned down for coverage by a malpractice insurance carrier? ☐ Yes ☒ No
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? ☐ Yes ☒ No
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)? ☐ Yes ☒ No
16. To your knowledge, are you the subject of an investigation for a criminal act? ☐ Yes ☒ No

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
APPLICATION FOR LICENSURE - PHYSICIAN - MEDICAL DOCTOR, 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:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

"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 medicine with reasonable skill and safety? If "yes," please explain. [REDACTED]
18. Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? If "yes," please explain. [REDACTED]
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. [REDACTED]
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. [REDACTED]
21. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If "yes," please explain. [REDACTED]
22. Are you currently engaged in the illegal use of controlled substances? [REDACTED]
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 illegally using controlled substances? If "yes," please explain. [REDACTED]
24. Have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder? [REDACTED]

FORM A - PLEASE PROVIDE EXPLANATIONS TO SECTION III "YES" ANSWERS ON THIS FORM

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
APPLICATION FOR LICENSURE - PHYSICIAN - MEDICAL DOCTOR, PAGE ONE OF SEVEN

Your Name: Bairlyn B Thomas

MEDICAL MALPRACTICE CLAIM (QUESTION 12) You will need TABLE I on Page 3 to complete this section. Please supply the following information regarding each instance of alleged malpractice: This form should be photocopied and filled out separately for each claim. Additional sheets may be attached if necessary. Please type or print clearly.

Insurer: PMSLIC

Claimant Name: Deborah Dougherty

Description of Alleged Basis(es) of Claim (Allegations Only: This does not constitute an admission of fault or liability.) See Codes on TABLE I, Page 3.

Basis Code: T 6 3 Basis Code: _____

Basis Code: _____ Basis Code: _____

Additional Descriptive Information - 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; and
- 4) Your degree of responsibility for the course of treatment in leading to the claim.

Patient underwent hysterectomy with resultant
femoral nerve palsy - I was the
attending physician with full
responsibility for her care

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

Incident Location (circle one):

01 Emergency Room
05 Outpatient
09 HMO
13 Walk-In Center

02 Labor/Delivery
06 Patient Room
10 Clinic
14 Other _____

03 Laboratory/X-Ray/Testing
07 Hospital-Other
11 Nursing Home
15 Unknown

04 Operating Room
08 Hospital-Unknown
12 Physician's Office

Question 12 continued on next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - APPLICATION FOR LICENSURE - PHYSICIAN - MEDICAL DOCTOR, PAGE TWO OF SEVEN

MEDICAL MALPRACTICE CLAIM (QUESTION 12) CONTINUED

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 Compensation Evaluator |
| 06 Surgeon | 16 Court Psychiatrist |
| 07 Fellow | 17 On-Call Physician |
| 08 PGY 1 | 18 Group Practitioner/Partner |
| 09 PGY 2 | 19 Other: Specify _____ |
| 10 PGY 3 | 20 Unknown |

Legal Representative (include name, address and telephone number):

Name: Don Camhi
Firm: POST & Schell, P.C.
Address: 1800 John F. Kennedy Boulevard
City, State, Zip: Philadelphia, PA 19103-7480
Telephone Number: (215) 587-1015

Indicate Decision, Appeal, Settlement, Dismissal: Case pending

If a Court or Arbitration Panel heard your case, indicate the following:

Decision determined by (Check one): ☐ Judge ☐ Jury ☐ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date Appeal Filed (Month, Day, Year) _____ / _____ / _____
Date Appeal Decided: _____ / _____ / _____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of Settlement: (Month, Day, Year) _____ / _____ / _____

☐ Case dismissed against you ☐ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

Case pending

DELAWARE COUNTY COURT OF COMMON PLEAS
OFFICE OF COURT ADMINISTRATION
CIVIL PROGRAM

AUTOMATIC CERTIFICATION

(To Be Filed In Duplicate)

Full Case Caption

Deborah Dougherty and John Dougherty, h/w
vs.

Gailyn B. Thomas, M.D., Ingrid E. Kotch, M.D.,
Suburban Ob/Gyn, Inc., Women's Health Source, P.C.,
and Crozer-Chester Medical Center

Case Record Number

99-11362

Complaint Date or

Writ Date

Type of Trial

(XX) Jury
() Non-Jury
() Arbitration

Kind of Case

() Civil Action
() Equity
() Malpractice (Non-Medical)
(XX) Malpractice (Medical)

() Asbestos
() Arbitration Appeal
() Other:

Total Amount of Suit in excess of \$50,000.00

Approximate Trial Time: 4 days

Expected Number of Witnesses 4-6

Attorney/Unrepresented Parties

Supreme Court I.D. # 03644 and 71498
Name: Arthur G. Raynes and James C. King
Address: Raynes, McCarty, Binder, Ross & Mundy
1845 Walnut St., 20th Flr., Phila., PA 19103
Phone: 215-568-6190 Atty For: Plaintiffs

Supreme Court I.D. # _____
Name: Gailyn B. Thomas, M.D.
Address: One Medical Center Blvd.,
Upland, PA 19013
Phone: _____ Atty For: _____

Supreme Court I.D. # _____
Name: Ingrid E. Kotch, M.D.
Address: 130 Tarrytown Rd.
Rochester, NY 14618
Phone: _____ Atty For: _____

Supreme Court I.D. # _____
Name: Suburban Ob/Gyn, Inc.
Address: 100 East Chester Pike
Ridley Park, PA 19078
Phone: _____ Atty For: _____

Supreme Court I.D. # _____
Name: Women's Health Source, P.C.
Address: One Medical Center Blvd.
Upland, PA 19013
Phone: _____ Atty For: _____

Supreme Court I.D. # _____
Name: Crozer-Chester Medical Center
Address: One Medical Center Blvd.
Upland, PA 19013
Phone: _____ Atty For: _____

Companion Cases: Are there any companion cases? () YES (XXX) NO

"YES," attach a similar certificate for any companion case(s) or explain reason(s) for its absence.

IN THE COURT OF COMMON PLEAS OF DELAWARE COUNTY, PENNSYLVANIA
CIVIL ACTION - LAW

DEBORAH DOUGHERTY and
JOHN DOUGHERTY, h/w
227 East Fourth Street
Media, PA 19063

v.

GAILYN B. THOMAS, M.D. *pm*
One Medical Center Boulevard
Upland, PA 19013

and

INGRID E. KOTCH, M.D. *WVF*
130 Tarrytown Road
Rochester, NY 14618

and

SUBURBAN OB/GYN, INC. *WVF*
100 East Chester Pike
Ridley Park, PA 19078

and

WOMEN'S HEALTH SOURCE, P.C. *pm*
One Medical Center Boulevard
Upland, PA 19013

and

CROZER-CHESTER MEDICAL CENTER
One Medical Center Boulevard
Upland, PA 19013

NO. *99-11363*

JURY TRIAL DEMANDED

NP

FILED
SEP 2 3 51 PM '99
CLERK OF
JUDICIAL DISTRICT
DELAWARE COUNTY

99-11362

NOTICE TO DEFEND

You have been sued in Court. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this Complaint and Notice are served by entering a written appearance personally or by an attorney and by filing in writing with the Court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so, the case may proceed without you, and a judgment may be entered against you by the Court without further notice for any money claimed in the Complaint or for any other claim or relief requested by the Plaintiff. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE.

IF YOU DO NOT HAVE A LAWYER OR CANNOT AFFORD ONE, GO TO OR TELEPHONE THE OFFICES SET FORTH BELOW TO FIND OUT WHERE YOU CAN GET LEGAL HELP.

Lawyers Reference Service
Delaware County Bar Association
Front and Lemon Streets
Media, PA 19063
(215) 566-6625

Pennsylvania Lawyer Referral Service
P.O. Box 1086
100 South Street
Harrisburg, PA 17108
(800) 692-7375

FILED
SEP 23 3 51 PM '99
OFFICE OF
JUDICIAL SERVICES
DELAWARE COUNTY

COMPLAINT

1. Plaintiffs Deborah Dougherty and her husband John Dougherty reside at 227 East Fourth Street, Media, PA
2. Defendant Gailyn B. Thomas, M.D. is a physician licensed to practice medicine in the Commonwealth of Pennsylvania, who presently maintains an office for that practice at One Medical Center Boulevard, Upland, PA, and at all times relevant hereto maintained an office for that practice at 100 East Chester Pike, Ridley Park, PA
3. Defendant Ingrid E. Kotch, M.D. at all times relevant hereto was a physician licensed to practice medicine in the Commonwealth of Pennsylvania, and who presently resides at 130 Tarrytown Road, Rochester, NY
4. At all times relevant hereto, Defendant Dr. Kotch was acting as the agent, servant, employee or ostensible agent of Defendant Dr. Thomas.
5. At all times relevant hereto, Defendant Dr. Thomas was acting as the agent, servant, employee or ostensible agent of Defendant Dr. Kotch.
6. Defendant Suburban OB/GYN, Inc. is a professional corporation or other legal entity organized and existing under the laws of the Commonwealth of Pennsylvania, and at all times relevant hereto maintained an office for the practice of medicine at 100 East Chester Pike, Ridley Park, PA
7. At all times relevant hereto, Defendant Dr. Thomas was acting as the agent, servant, employee or ostensible agent of Defendant Suburban OB/GYN, Inc.
8. At all times relevant hereto, Defendant Dr. Kotch was acting as the agent, servant, employee or ostensible agent of Defendant Suburban OB/GYN, Inc.

9. Defendant Women's Health Source, P.C., is a professional corporation or other legal entity organized and existing under the laws of the Commonwealth of Pennsylvania, and at all times relevant hereto maintained an office for the practice of medicine at One Medical Center Boulevard, Upland, PA

10. At all times relevant hereto, Defendant Dr. Thomas was acting as the agent, servant, employee or ostensible agent of Defendant Women's Health Source, P.C.

11. At all times relevant hereto, Defendant Dr. Kotch was acting as the agent, servant, employee or ostensible agent of Defendant Women's Health Source, P.C.

12. Defendant Crozer-Chester Medical Center is a corporation or other legal entity organized and existing under the laws of the Commonwealth of Pennsylvania, and at all times relevant hereto owned, operated, controlled and/or maintained a hospital and/or health care facility at One Medical Center Boulevard, Upland, PA

13. At all times relevant hereto, Defendant Dr. Thomas was acting as the agent, servant, employee or ostensible agent of Defendant Crozer-Chester Medical Center.

14. At all times relevant hereto, Defendant Dr. Kotch was acting as the agent, servant, employee or ostensible agent of Defendant Crozer-Chester Medical Center.

15. At all times relevant hereto, Defendant Dr. Thomas held herself out to the public in general and in particular to Plaintiff Deborah Dougherty as a skilled and competent physician specializing in the field of obstetrics and gynecology.

16. At all times relevant hereto, Defendant Dr. Kotch held herself out to the public in general and in particular to Plaintiff Deborah Dougherty as a skilled and competent physician specializing in the field of obstetrics and gynecology.

17. At all times relevant hereto, Defendant Suburban OB/GYN, Inc., by and through its partners, joint venturers, agents, servants, employees and/or ostensible agents, held itself out to the public in general and in particular to Plaintiff Deborah Dougherty as a medical group providing skilled and competent care in the field of obstetrics and gynecology.

18. At all times relevant hereto, Defendant Women's Health Source, P.C., by and through its partners, joint venturers, agents, servants, employees and/or ostensible agents, held itself out to the public in general and in particular to Plaintiff Deborah Dougherty as a medical group providing skilled and competent care in the field of obstetrics and gynecology.

19. At all times relevant hereto, Defendant Crozer-Chester Medical Center, by and through its partners, joint venturers, agents, servants, employees and/or ostensible agents, held itself out to the public in general and in particular to Plaintiff Deborah Dougherty as a hospital and/or health care facility providing skilled and competent medical care and attention to patients in need of its services.

20. At all times relevant hereto, Plaintiff Deborah Dougherty was under the medical care and treatment of the Defendants herein, their agents, servants, employees and/or ostensible agents.

21. On or about March 19, 1997, Plaintiff Deborah Dougherty came under the care of Defendant Dr. Thomas for gynecologic care.

22. On or about March 19, 1997, Plaintiff Deborah Dougherty came under the care of Defendant Dr. Kotch for gynecologic care.

23. On or about March 19, 1997, Plaintiff Deborah Dougherty came under the care of Defendant Suburban OB/GYN, Inc. for gynecologic care.

24. On or about March 19, 1997, Plaintiff Deborah Dougherty came under the care of Defendant Women's Health Source, P.C. for gynecologic care.
25. On or about September 16, 1997, Plaintiff Deborah Dougherty underwent a total abdominal hysterectomy and bilateral salpingo-oophorectomy at Defendant Crozer-Chester Medical Center.
26. The surgery was performed by and/or under the direction of Defendant Dr. Thomas at Defendant Crozer-Chester Medical Center.
27. Defendant Dr. Kotch assisted Defendant Dr. Thomas in the surgery performed on Plaintiff Deborah Dougherty on September 16, 1997 at Defendant Crozer-Chester Medical Center.
28. During the course of the surgery performed by Defendants on September 16, 1997, Plaintiff Deborah Dougherty sustained an injury to her left femoral nerve.
29. During the course of the surgery performed by Defendants, Plaintiff Deborah Dougherty was under the exclusive surgical care and/or control of Defendants.
30. During the course of the surgery performed by Defendants on September 16, 1997, Defendant Dr. Thomas and/or Defendant Dr. Kotch and/or their agents, servants, employees and/or ostensible agents injured the left femoral nerve of Plaintiff Deborah Dougherty.
31. As the direct and proximate result of the negligence and carelessness of the defendants herein, Plaintiff Deborah Dougherty suffered and continues to suffer severe complications, including but not limited to injury to her left femoral nerve, left leg pain, weakness, burning, numbness, swelling, temperature sensitivity, lower back and right leg pain

and decreased mobility, which complications have resulted in the damages and losses described below.

32. The negligence and carelessness of Defendant Dr. Thomas consisted of the following:

- a). applying and prescribing inadequate and/or inappropriate methods, techniques or procedures during the course of the surgery;
- b). failing to employ timely, adequate and appropriate techniques and procedures during the course of the surgery;
- c). performing the surgery in such a manner as to cause injury to Plaintiff's left femoral nerve;
- d). failing to properly identify, delineate, dissect and otherwise safeguard Plaintiff's left femoral nerve during the course of the surgery;
- e). failing to timely consult with appropriate specialists regarding Plaintiff's condition, diagnosis and treatment;
- f). failing to implement appropriate alternative therapies or treatments as indicated in this surgical setting;
- g). failing to use safe and appropriate equipment and materials during the surgery;
- h). failing to properly monitor Plaintiff's condition during the surgery;
- i). failing to monitor the use of equipment and materials used during the course of the surgery to insure that it did not injure Plaintiff's left femoral nerve;

j). failing to properly instruct her agents, servants, employees and/or ostensible agents in the appropriate use of surgical equipment and proper surgical technique;

k). failing to act in accordance with the appropriate standards of surgical care;

l). failing to act in accordance with the appropriate standards of gynecological surgical care;

m). failing to act with the requisite surgical skill in the performance of the surgery; and

n). failing to oversee all persons under her supervision who provided care and assistance in the surgery.

33. The negligence and carelessness of Defendant Dr. Thomas was a direct and proximate cause of the injuries and damages that Plaintiffs Deborah Dougherty and John Dougherty have suffered and will continue to suffer in the future as more particularly described herein.

34. The negligence and carelessness of Defendant Dr. Kotch consisted of the following:

a). applying and prescribing inadequate and/or inappropriate methods, techniques or procedures during the course of the surgery;

b). failing to employ timely, adequate and appropriate techniques and procedures during the course of the surgery;

c). performing the surgery in such a manner as to cause injury to Plaintiff's left femoral nerve;

- d). failing to properly identify, delineate, dissect and otherwise safeguard Plaintiff's left femoral nerve during the course of the surgery;
- e). failing to timely consult with appropriate specialists regarding Plaintiff's condition, diagnosis and treatment;
- f). failing to implement appropriate alternative therapies or treatments as indicated in this surgical setting;
- g). failing to use safe and appropriate equipment and materials during the surgery;
- h). failing to properly monitor Plaintiff's condition during the surgery;
- i). failing to monitor the use of equipment and materials used during the course of the surgery to insure that it did not injure Plaintiff's left femoral nerve;
- j). failing to properly instruct her agents, servants, employees and/or ostensible agents in the appropriate use of surgical equipment and proper surgical technique;
- k). failing to act in accordance with the appropriate standards of surgical care;
- l). failing to act in accordance with the appropriate standards of gynecological surgical care;
- m). failing to act with the requisite surgical skill in the performance of the surgery; and
- n). failing to oversee all persons under her supervision who provided care and assistance in the surgery.

35. The negligence and carelessness of Defendant Dr. Kotch was a direct and proximate cause of the injuries and damages that Plaintiffs Deborah Dougherty and John Dougherty have suffered and will continue to suffer in the future as more particularly described herein.

36. The negligence and carelessness of Defendant Suburban OB/GYN, Inc., by and through its agents, servants, employees and/or ostensible agents, consisted of the following:

- a). applying and prescribing inadequate and/or inappropriate methods, techniques or procedures during the course of the surgery;
- b). failing to employ timely, adequate and appropriate techniques and procedures during the course of the surgery;
- c). performing the surgery in such a manner as to cause injury to Plaintiff's left femoral nerve;
- d). failing to properly identify, delineate, dissect and otherwise safeguard Plaintiff's left femoral nerve during the course of the surgery;
- e). failing to timely consult with appropriate specialists regarding Plaintiff's condition, diagnosis and treatment;
- f). failing to implement appropriate alternative therapies or treatments as indicated in this surgical setting;
- g). failing to use safe and appropriate equipment and materials during the surgery;
- h). failing to properly monitor Plaintiff's condition during the surgery;

- i). failing to monitor the use of equipment and materials used during the course of the surgery to insure that it did not injure Plaintiff's left femoral nerve;
- j). failing to properly instruct its agents, servants, employees and/or ostensible agents in the appropriate use of surgical equipment and proper surgical technique;
- k). failing to act in accordance with the appropriate standards of surgical care;
- l). failing to act in accordance with the appropriate standards of gynecological surgical care;
- m). failing to act with the requisite surgical skill in the performance of the surgery;
- n). failing to oversee all persons under its supervision who provided care and assistance in the surgery;
- o). failing to oversee all persons who provided medical and nursing care and treatment during the surgery;
- p). failing to properly supervise and/or instruct its partners, joint venturers, agents, ostensible agents, servants and/or employees and/or those providing medical care and treatment to Plaintiff Deborah Dougherty;
- q). failing to select and retain competent gynecological surgeons and operating room staff;
- r). failing to provide competent, trained and experienced care and management to persons, including Plaintiff Deborah Dougherty, who sought such medical care;

s). failing to provide the necessary personnel and equipment to care for and treat Plaintiff Deborah Dougherty;

t). failing to institute appropriate policies and procedures for the performance of the surgery to ensure the quality of care to its patients, including Plaintiff Deborah Dougherty; and

u). failing to adhere to any such policies and procedures that did exist regarding the performance of the surgery on Deborah Dougherty.

37. The negligence and carelessness of Defendant Suburban OB/GYN, Inc., by and through its agents, servants, employees and/or ostensible agents, was a direct and proximate cause of the injuries and damages that Plaintiffs Deborah Dougherty and John Dougherty have suffered and will continue to suffer in the future as more particularly described herein.

38. The negligence and carelessness of Defendant Women's Health Source, P.C., by and through its agents, servants, employees and/or ostensible agents, consisted of the following:

a). applying and prescribing inadequate and/or inappropriate methods, techniques or procedures during the course of the surgery;

b). failing to employ timely, adequate and appropriate techniques and procedures during the course of the surgery;

c). performing the surgery in such a manner as to cause injury to Plaintiff's left femoral nerve;

d). failing to properly identify, delineate, dissect and otherwise safeguard Plaintiff's left femoral nerve during the course of the surgery;

- e). failing to timely consult with appropriate specialists regarding Plaintiff's condition, diagnosis and treatment;
- f). failing to implement appropriate alternative therapies or treatments as indicated in this surgical setting;
- g). failing to use safe and appropriate equipment and materials during the surgery;
- h). failing to properly monitor Plaintiff's condition during the surgery;
- i). failing to monitor the use of equipment and materials used during the course of the surgery to insure that it did not injure Plaintiff's left femoral nerve;
- j). failing to properly instruct its agents, servants, employees and/or ostensible agents in the appropriate use of surgical equipment and proper surgical technique;
- k). failing to act in accordance with the appropriate standards of surgical care;
- l). failing to act in accordance with the appropriate standards of gynecological surgical care;
- m). failing to act with the requisite surgical skill in the performance of the surgery;
- n). failing to oversee all persons under its supervision who provided care and assistance in the surgery;
- o). failing to oversee all persons who provided medical and nursing care and treatment during the surgery;

- p). failing to properly supervise and/or instruct its partners, joint venturers, agents, ostensible agents, servants and/or employees and/or those providing medical care and treatment to Plaintiff Deborah Dougherty;
- q). failing to select and retain competent gynecological surgeons and operating room staff;
- r). failing to provide competent, trained and experienced care and management to persons, including Plaintiff Deborah Dougherty, who sought such medical care;
- s). failing to provide the necessary personnel and equipment to care for and treat Plaintiff Deborah Dougherty;
- t). failing to institute appropriate policies and procedures for the performance of the surgery to ensure the quality of care to its patients, including Plaintiff Deborah Dougherty; and
- u). failing to adhere to any such policies and procedures that did exist regarding the performance of the surgery on Deborah Dougherty;

39. The negligence and carelessness of Defendant Women's Health Source, P.C., by and through its agents, servants, employees and/or ostensible agents, was a direct and proximate cause of the injuries and damages that Plaintiffs Deborah Dougherty and John Dougherty have suffered and will continue to suffer in the future as more particularly described herein.

40. The negligence and carelessness of Defendant Crozer-Chester Medical Center, by and through its agents, servants, employees and ostensible agents, consisted of the following:

- a). applying and prescribing inadequate and/or inappropriate methods, techniques or procedures during the course of the surgery;
- b). failing to employ timely, adequate and appropriate techniques and procedures during the course of the surgery;
- c). performing the surgery in such a manner as to cause injury to Plaintiff's left femoral nerve;
- d). failing to properly identify, delineate, dissect and otherwise safeguard Plaintiff's left femoral nerve during the course of the surgery;
- e). failing to timely consult with appropriate specialists regarding Plaintiff's condition, diagnosis and treatment;
- f). failing to implement appropriate alternative therapies or treatments as indicated in this surgical setting;
- g). failing to use safe and appropriate equipment and materials during the surgery;
- h). failing to properly monitor Plaintiff's condition during the surgery;
- i). failing to monitor the use of equipment and materials used during the course of the surgery to insure that it did not injure Plaintiff's left femoral nerve;
- j). failing to properly instruct its agents, servants, employees and/or ostensible agents in the appropriate use of surgical equipment and proper surgical technique;
- k). failing to act in accordance with the appropriate standards of surgical care;

- l). failing to act in accordance with the appropriate standards of gynecological surgical care;
- m). failing to act with the requisite surgical skill in the performance of the surgery;
- n). failing to oversee all persons under its supervision who provided care and assistance in the surgery;
- o). failing to oversee all persons who provided medical and nursing care and treatment during the surgery;
- p). failing to properly supervise and/or instruct its partners, joint venturers, agents, ostensible agents, servants and/or employees and/or those providing medical care and treatment to Plaintiff Deborah Dougherty;
- q). failing to select and retain competent gynecological surgeons and operating room staff;
- r). failing to provide competent, trained and experienced care and management to persons, including Plaintiff Deborah Dougherty, who sought such medical care;
- s). failing to provide the necessary personnel and equipment to care for and treat Plaintiff Deborah Dougherty;
- t). failing to institute appropriate policies and procedures for the performance of the surgery to ensure the quality of care to its patients, including Plaintiff Deborah Dougherty; and
- u). failing to adhere to any such policies and procedures that did exist regarding the performance of the surgery on Deborah Dougherty.

41. The negligence and carelessness of Defendant Crozer-Chester Medical Center, by and through its agents, servants, employees and ostensible agents, was a direct and proximate cause of the injuries and damages that Plaintiffs Deborah Dougherty and John Dougherty have suffered and will continue to suffer in the future as more particularly described herein.

COUNT I

42. Plaintiffs Deborah Dougherty and John Dougherty incorporate by reference the above paragraphs as if fully set forth herein at length.

43. As the direct and proximate result of the negligence and carelessness of the Defendants, as described in the foregoing paragraphs, Plaintiff Deborah Dougherty sustained severe and disabling injuries, including but not limited to injury to her left femoral nerve, left leg pain, weakness, burning, numbness, swelling, temperature sensitivity, lower back and right leg pain and decreased mobility.

44. As the direct and proximate result of the negligence and carelessness of the Defendants, as described in the foregoing paragraphs, Defendants increased the risk that Plaintiff Deborah Dougherty would suffer the harm, injuries and damages that she has incurred.

45. As the direct and proximate result of the negligence and carelessness of the Defendants, as described in the foregoing paragraphs, Plaintiff Deborah Dougherty has in the past and may in the future be required to undergo medical care and treatment, surgeries and hospitalizations that otherwise would have been unnecessary, all to her great detriment and loss.

46. As the direct and proximate result of the negligence and carelessness of the Defendants, as described in the foregoing paragraphs, Plaintiff Deborah Dougherty has incurred in the past and may in the future incur substantial expenses for medical care and treatment that otherwise would have been unnecessary, to her great detriment and loss.

47. As the direct and proximate result of the negligence and carelessness of the Defendants, as described in the foregoing paragraphs, Plaintiff Deborah Dougherty has in the past and may in the future sustain a loss of earnings and earning capacity, all to her great detriment and loss.

48. As the direct and proximate result of the negligence and carelessness of the Defendants, as described in the foregoing paragraphs, Plaintiff Deborah Dougherty has in the past and may in the future be unable to attend to her usual daily activities, occupations and avocations, all to her great detriment and loss.

49. As the direct and proximate result of the negligence and carelessness of the Defendants, as described in the foregoing paragraphs, Plaintiff Deborah Dougherty has suffered in the past and may suffer in the future grievous physical pain, mental anguish and emotional upset and suffering, disfigurement, humiliation, inconvenience and loss of life's pleasures.

WHEREFORE, Plaintiff Deborah Dougherty claims of Defendants, and each of them, both jointly and severally, an amount in excess of the jurisdictional amount requiring arbitration referral pursuant to the local rules of Delaware County.

COUNT II

50. Plaintiffs Deborah Dougherty and John Dougherty incorporate by reference the above paragraphs as if fully set forth herein at length.

51. As the direct and proximate result of the negligence and carelessness of the Defendants as described in the foregoing paragraphs, Plaintiff John Dougherty, as the husband and partner of Plaintiff Deborah Dougherty, has been deprived of the society, companionship, consortium and services of his wife and will be so deprived for an indefinite time in the future.

WHEREFORE, Plaintiff Deborah Dougherty claims of Defendants, and each of them, both jointly and severally, an amount in excess of the jurisdictional amount requiring arbitration referral pursuant to the local rules of Delaware County.

COUNT III

52. Plaintiffs Deborah Dougherty and John Dougherty incorporate by reference the above paragraphs as if fully set forth herein at length.

53. Defendant Dr. Thomas and/or Defendant Dr. Kotch and/or her or their agents, servants, employees and/or ostensible agents failed to advise Plaintiff of the risks, alternatives and complications of the surgery performed on Plaintiff Deborah Dougherty on September 16, 1997.

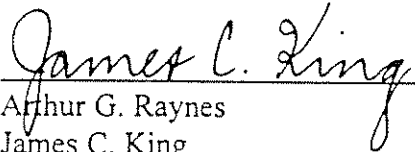
54. Defendant Dr. Thomas and/or Defendant Dr. Kotch and/or her or their agents, servants, employees and/or ostensible agents failed to obtain the informed consent of Plaintiff Deborah Dougherty prior to performing surgery on her on September 16, 1997.

55. Defendant Dr. Thomas and/or Defendant Dr. Kotch and/or her or their agents, servants, employees and/or ostensible agents committed a battery upon plaintiff Deborah Dougherty.

WHEREFORE. Plaintiffs Deborah Dougherty and John Dougherty claim of Defendants Gailyn B. Thomas. M.D., Suburban OB-GYN, Inc., Crozer-Chester Medical Center and Women's Health Source. P.C., and each of them, both jointly and severally, a sum in an amount in excess of the jurisdictional amount requiring arbitration referral, plus interest and costs of suit.

RAYNES, McCARTY, BINDER, ROSS & MUNDY

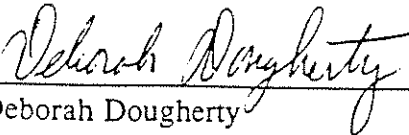
By:


Arthur G. Raynes
James C. King
1845 Walnut Street, Suite 2000
Philadelphia, PA 19103
(215) 568-6190

Attorneys for Plaintiffs,
Deborah and John Dougherty

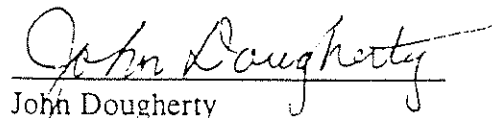
VERIFICATION

I, Deborah Dougherty, state that I am a Plaintiff in this action; that I am acquainted with the facts contained in the foregoing Complaint; that the facts contained therein are true and correct to the best of my knowledge, information and belief; and that this statement is made subject to the penalties of 18 Pa. C.S.A. § 4904 relating to unsworn falsification to authorities.


Deborah Dougherty

VERIFICATION

I, John Dougherty, state that I am a Plaintiff in this action; that I am acquainted with the facts contained in the foregoing Complaint; that the facts contained therein are true and correct to the best of my knowledge, information and belief; and that this statement is made subject to the penalties of 18 Pa. C.S.A. § 4904 relating to unsworn falsification to authorities.


John Dougherty

FORM A - PLEASE PROVIDE EXPLANATIONS TO SECTION III "YES" ANSWERS ON THIS FORM

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
APPLICATION FOR LICENSURE - PHYSICIAN - MEDICAL DOCTOR, PAGE ONE OF SEVEN

Your Name: Carolyn B Thomas

MEDICAL MALPRACTICE CLAIM (QUESTION 12) You will need TABLE I on Page 3 to complete this section. Please supply the following information regarding each instance of alleged malpractice: This form should be photocopied and filled out separately for each claim. Additional sheets may be attached if necessary. Please type or print clearly.

Insurer: PIC

Claimant Name: Karen Bowermaster

Description of Alleged Basis(es) of Claim (Allegations Only: This does not constitute an admission of fault or liability.) See Codes on TABLE I, Page 3.

Basis Code: T S 3 Basis Code: _____

Basis Code: _____ Basis Code: _____

Additional Descriptive Information - 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; and
- 4) Your degree of responsibility for the course of treatment in leading to the claim.

Term labor patient undergoing spontaneous vaginal delivery. Shoulder dystocia encountered. Infant with subsequent brachial plexus injury. I was the attending physician solely responsible for the delivery

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

Incident Location (circle one):

01 Emergency Room
05 Outpatient
09 HMO
13 Walk-In Center

02 Labor/Delivery

06 Patient Room

10 Clinic

14 Other _____

03 Laboratory/X-Ray/Testing

07 Hospital-Other

11 Nursing Home

15 Unknown

04 Operating Room

08 Hospital-Unknown

12 Physician's Office

Question 12 continued on next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - APPLICATION FOR LICENSURE - PHYSICIAN - MEDICAL DOCTOR, PAGE TWO OF SEVEN

MEDICAL MALPRACTICE CLAIM (QUESTION 12) CONTINUED

Your Role (circle one):

- | | |
|-------------------------------|-------------------------------------|
| 01 Anesthesiologist | 11 PGY 4 |
| 02 Primary Care Physician | 12 PGY 5 |
| 03 Referring Physician | 13 PGY 6 |
| <u>04 Attending Physician</u> | 14 PGY 7 |
| 05 Consultant Specialist | 15 Workmen's Compensation Evaluator |
| 06 Surgeon | 16 Court Psychiatrist |
| 07 Fellow | 17 On-Call Physician |
| 08 PGY 1 | 18 Group Practitioner/Partner |
| 09 PGY 2 | 19 Other: Specify _____ |
| 10 PGY 3 | 20 Unknown |

Legal Representative (include name, address and telephone number):

Name: George Young

Firm: Wright, Young & McGilvery, P.C.

Address: 1400 Union Meeting Road Suite 220

City, State, Zip: Blue Bell, PA 19422-3006

Telephone Number: (215) 654-1400

Indicate Decision, Appeal, Settlement, Dismissal:

If a Court or Arbitration Panel heard your case, indicate the following:

Decision determined by (Check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date Appeal Filed (Month, Day, Year) _____ / _____ / _____

Date Appeal Decided: _____ / _____ / _____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: \$ 725,000

Total settlement amount: \$ 725,000

Date of Settlement: (Month, Day, Year) 08 / 31 / 99

_____ Case dismissed against you _____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

Table I for Question 12 on the next page

WRIGHT, YOUNG & McGILVERY, P.C.
ATTORNEYS AT LAW

KEVIN H. WRIGHT
GEORGE L. YOUNG, JR.
MICHAEL E. McGILVERY
DENISE L. JULIANA *
MARK R. ZOLFAGHARI
DAVID R. FRIEDMAN *
MARY ELLEN MENZ
MICHAEL A. MULLEN *
MARY GRADY WALSH *
DIANE L. LYNCH
SYLVAN A. SELYA
VINCENT G. GUEST

* Also Admitted New Jersey Bar

1400 UNION MEETING ROAD
Suite 220 - P.O. Box 3006
Blue Bell, Pennsylvania 19422-3006
(215) 654-1400
FAX (215) 654-0540

PLEASE RESPOND TO:
BLUE BELL OFFICE

September 15, 1999

PHILADELPHIA OFFICE:
The Widener Building
The Mezzanine - Suite 240
One South Penn Square
Philadelphia, PA 19107
(215) 567-3400
FAX (215) 567-8536

NEW JERSEY OFFICE:
Washington Professional Campus
900 Route 168 (Black Horse Pike)
Suite B-3
Turnersville, NJ 08012-1453
(609) 227-8602
FAX (609) 227-8507

Gailyn B. Thomas, M.D.
Women's Health Source
CCMC/ACP Suite 331
#1 Medical Center Blvd.
Upland, PA 19013

RE: Bowermaster v. Thomas, M.D., et al.
Our File No. 108-134

Dear Dr. Thomas:

Please allow this letter to follow up my paralegal's telephone advices to the effect that the above-captioned matter has been settled for \$725,000.00. Therefore, the trial of this case which was scheduled for October 18th will not go forward.

This matter is now over and you need concern yourself with it no further. We will forward a copy of all closing papers to your attention once they are filed with the Court.

Many thanks for your courtesies throughout the course of this litigation.

Very truly yours,

WRIGHT, YOUNG & McGILVERY, P.C.

BY: 

GLY/mbb

MARKS, FEINER & FRIDKIN, P.C.
BY: MARK S. FRIDKIN, ESQUIRE
IDENTIFICATION NO. 17462
800 STEPHEN GIRARD BUILDING
21 SOUTH 12TH STREET
PHILADELPHIA, PENNSYLVANIA 19107
(215)563-7888

Box 3321

Attorney for Plaintiff(s)

BRIANNA BOWERMASTER, a minor by
her parents and natural guardians, KAREN
BOWERMASTER and
WILLIAM BOWERMASTER, and
KAREN BOWERMASTER and
WILLIAM BOWERMASTER, in their
own right

COURT OF COMMON PLEAS
DELAWARE COUNTY

v.

GAILYN THOMAS, M.D., SUBURBAN
OB-GYN, LTD. And
CROZER CHESTER MEDICAL
CENTER

NO. 96-3940

ORDER

AND NOW, to wit this 27th day of MAR, 2000, upon consideration
of the within Petition To Compromise Minor's Claim, it is hereby ORDERED and
DECREED that:

1. The settlement in compromise of the above case in the gross sum of
\$725,000.00 is approved.
2. The creation of a trust for the benefit of Brianna Bowermaster, in substantially
the same form as attached as Exhibit "A" hereto, of which The Trust Company of Lehigh
Valley will serve as the initial Corporate Trustee and Karen Bowermaster will serve as the
initial Individual Trustee, is approved.

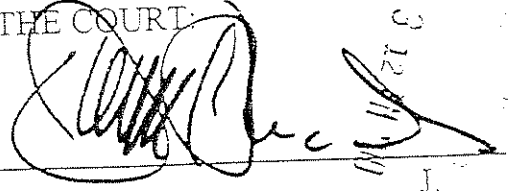
3. That distribution is to be made as follows:

GROSS AMOUNT OF SETTLEMENT:	\$725,000.00
TO: MARKS, FEINER & FRIDKIN, P.C.	\$ 17,827.37
Reimbursement of Costs	
TO: MARKS, FEINER & FRIDKIN, P.C. - FEE	\$176,793.16
25% of Net Settlement	
TO: THE TRUST COMPANY OF LEHIGH VALLEY, CORPORATE TRUSTEE, AND KAREN BOWERMASTER, INDIVIDUAL TRUSTEE, TO BE HELD PURSUANT TO THE TERMS OF THE AFORESAID DECLARATION OF TRUST	\$530,379.47

4. In order to effectuate the Declaration of Trust for the Benefit of Brianna Bowermaster, Karen Bowermaster and Mark S. Fridkin, Esquire are hereby specifically authorized to withdraw any and all monies from the following accounts to be distributed in accordance with this Order:

First Union National Bank	Acct. #1010003244416	\$90,625.00
Sovereign Bank	Acct. #0961042338	\$90,625.00
Patriot Bank	Acct. #5300552741	\$90,625.00
First Trust Bank	Acct. #60061987803	\$90,625.00
National Penn Bank	Acct. #0415685	\$90,625.00
PNC Bank	Acct. #900657164	\$90,625.00
Keystone Savings Bank	Acct. #035500134	\$90,625.00
American Bank	Acct. #100010923	<u>\$90,625.00</u>
Total:		\$725,000.00

BY THE COURT:


J.

FULL AND FINAL RELEASE

1. **FOR AND IN CONSIDERATION** of payment of the statutory primary coverage limit of Gailyn Thomas, M.D. pursuant to the provisions of the Pennsylvania Property and Casualty Insurance Guaranty Act; and for the promise of payment in the amount of \$525,000 made by the Medical Professional Liability Catastrophe Loss Fund, the undersigned do fully release and discharge Gailyn Thomas, M.D., Suburban Associates, the Medical Professional Liability Catastrophe Loss Fund, all other persons, associations and corporations whether or not named herein, their heirs, executors, administrators, successors, assigns and insurers, and their respective agents, servants and employees, from any or all causes of action, claims and demands of whatsoever kind on account of all known and unknown injuries, losses and damages allegedly sustained by the undersigned and, specifically, from any claims or joinders for sole liability, contribution, indemnity or otherwise as a result of, arising from, or in any way connected with all medical professional health care services rendered by the above named Health Care Providers, and on account of which Legal Action was instituted by the undersigned in the Court of Common Pleas of Delaware, Co., PA, Docket No. 96-3940. All sums set forth herein constitute damages on account of physical injuries and sickness, within the meaning of Section 104(a)(2) of the Internal Revenue Code of 1986, as amended. The undersigned does understand, and agrees, that the acceptance of said sum is in full accord and satisfaction of a disputed claim and that the payment of said sum is not an admission of liability by any party named herein.
2. It is understood and agreed that the primary insurer for Gailyn Thomas, M.D. was PIC Insurance Group, Inc., which has been declared insolvent and that the Pennsylvania Property and Casualty Insurance Guaranty Association has become the statutory primary insurer for Gailyn Thomas, M.D.. The amount to be paid by the Pennsylvania Property and Casualty Insurance Guaranty Association is subject to "Non-duplication of Recovery" (40 P.S. §991.1817(a)), which states: "Any person having a claim under an insurance policy shall be required to exhaust first his right under such policy. For purposes of this section, a claim under an insurance policy shall include a claim under any kind of insurance, whether it is a first-party or third party claim, and shall include, without limitation, accident and health insurance, worker's compensation, Blue Cross and Blue Shield and all other coverage's except policies of an insolvent insurer. Any amount payable on a covered claim under this act shall be reduced by the amount of recovery under other insurance." Therefore, the undersigned hereby agrees to accept the statutory primary limit of Gailyn Thomas, M.D., subject to the offset provisions of the Pennsylvania Property and Casualty Insurance Guaranty Association Act. If it should be finally determined by the Court that the offset provision of 40 P.S. §991.1817(b) is

invalid or if no recovery has been received by the undersigned under any other policy of insurance for damages claimed in the legal action noted above, the undersigned reserves the right to seek full recovery of the primary limit of Gailyn Thomas, M.D. exclusively from the Pennsylvania Property and Casualty Insurance Guaranty Association, which is statutorily and exclusively liable for said amount. The undersigned, their heirs, executors, successors and assigns hereby agree to seek or accept no further payment or compensation from the Medical Professional Liability Catastrophe Loss Fund, other than that stated in paragraph 1 of this release.

3. It is expressly understood and agreed that this release and settlement is intended to cover and does cover not only all now known injuries, losses and damages, but any further injuries, losses and damages which arise from, or are related to, the occurrence set forth in the Legal Action noted above.
4. The undersigned hereby agrees, on his/her/their behalf and on behalf of my/our heirs, executors, successors and/or assigns, to satisfy any and all liens that have been asserted and/or which could be or may be asserted for reimbursement of any medical benefits or other benefits provided to the undersigned by a third party as a result of the injuries claimed in the Legal Action referenced herein. Additionally, the undersigned hereby agrees, on his/her/their behalf and on behalf of my/our heirs, executors, successors and/or assigns, to indemnify and save forever harmless the Releasees named in this document from and against any and all claims, demands or actions, known or unknown, made against the Releasees by any person or entity on account of, or in any manner related to or arising from the Legal Action noted above.
5. In the event court approval is required for the settlement, compromise or resolution of this claim, this settlement is conditioned upon plaintiff undertaking any and all necessary action to obtain same.
6. If this settlement is ever determined by any court to be without effect because some necessary court approval was not obtained, or if the released parties are subjected to further legal action or claim which could not have been instituted or presented had proper court approval been obtained by plaintiff, then plaintiff will indemnify the released parties for any future loss, cost, or expense, including but not limited to, reasonable attorney's fees for defending, litigating and settling any such claims or action, and for any judgment resulting from any such claim or action.
7. It is further understood and agreed that this is the complete release agreement, and that there are no written

or oral understandings or agreements, directly or indirectly, connected with this release and settlement, that are not incorporated herein. This agreement shall be binding upon and inure to the successors, assigns, heirs, executors, administrators, and legal representatives of the respective parties hereto.

8. It is fully understood and agreed that the amount promised to be paid by the Medical Professional Liability Catastrophe Loss Fund shall not become payable until December 31, 1999.
9. It is further understood and agreed and made part hereof, that the undersigned, their family and representatives and their attorney(s) shall not comment, either directly or indirectly, on any aspect of this case or settlement to any member of the news media, or in any way publicize or cause to be publicized in any news or communications media, including but not limited to newspapers, magazines, journals, radio, television, on-line computer systems and law-related publications, the facts of this case, the existence of this settlement and the terms and conditions of this settlement. If the undersigned, their family, representatives and/or attorney(s) file any court document(s) identifying the terms and/or conditions of this settlement, they shall request that the court immediately seal such document(s) and take whatever reasonable steps are necessary to seek to assure that such document(s) are not accessible or disclosed to anyone. This paragraph is intended to become part of the consideration for settlement of this claim.
10. THE UNDERSIGNED HEREBY DECLARES that the terms of this settlement have been completely read; and that they have discussed the terms of this settlement with legal counsel of their choice; and said terms are fully understood and voluntarily accepted for the purpose of making a full and final compromise adjustment and settlement of any and all claims on account of the injuries and damages above-mentioned, and for the express purpose of precluding forever any further or additional suits arising out of the aforesaid claims.

DEC 29 1999 4:06PM
AUG 31 99 04:23P

610-336-9110-4502 P. 1

VO, 7577 P. 3

AUG 31 1999 3:37PM

12155605169

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 31st day of August
19 99.

Karen Bowermaster (SEAL)

Karen Bowermaster, Individually and Parent and Natural
Guardian of Brianna Bowermaster, a Minor

096 60 3172

Social Security Number

[Signature] (SEAL)

William Bowermaster, Individually and Parent and Natural
Guardian of Brianna Bowermaster, a Minor

035380504

Social Security Number

Malis F...
Witness

ASSESSMENT OF DAMAGES HEARING IS REQUIRED
JURY TRIAL DEMANDED

RECEIVED MAY - 9 1996

APR 8 2 15 PM '96
OFFICE OF
JUDICIAL SUPPORT
DELAWARE CO. PA.

FILED

MARKS, FEINER & FRIDKIN, P.C.

BY: MARK S. FRIDKIN

IDENTIFICATION NO. 17462

800 STEPHEN GIRARD BUILDING

21 S. 12th STREET

PHILADELPHIA, PENNSYLVANIA 19107

(215) 563-7888

ATTORNEY FOR Plaintiffs

BRIANNA BOWERMASTER, a minor,
by her parents and natural
guardians, KAREN BOWERMASTER
and WILLIAM BOWERMASTER, and
KAREN BOWERMASTER and WILLIAM
BOWERMASTER in their own right
22 Chester Pike
Ridley Park, PA 19078

VS.

GAILYN THOMAS, M.D.
100 Chester Pike
Ridley Park, PA 19078

and

SUBURBAN ASSOCIATES
100 Chester Pike
Ridley Park, PA 19078

and

CROZER-CHESTER MEDICAL CENTER
15th and Upland Avenues
Upland, PA 19013

Delaware County
COURT OF COMMON PLEAS
CIVIL TRIAL DIVISION

TERM,

No. 96-3940

MAJOR JURY

COMPLAINT IN CIVIL ACTION

(Personal Injury - Medical Malpractice)

NOTICE

You have been sued in court. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this complaint and notice are served, by entering a written appearance personally or by attorney and filing in writing with the court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so the case may proceed without you and a judgment may be entered against you by the court without further notice for any money claimed in the complaint or for any other claim or relief requested by the plaintiff. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE A LAWYER OR CANNOT AFFORD ONE, GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW TO FIND OUT WHERE YOU CAN GET LEGAL HELP.

PHILADELPHIA BAR ASSOCIATION
LAWYER REFERRAL AND INFORMATION SERVICE
One Reading Center
Philadelphia, Pennsylvania 19107
Telephone: 215-238-1701

AVISO

Le han demandado a usted en la corte. Si usted quiere defenderse de estas demandas expuestas en las páginas siguientes, usted tiene veinte (20) días de plazo al partir de la fecha de la demanda y la notificación. Hace falta asentar una comparecencia escrita o en persona o con un abogado y entregar a la corte en forma escrita sus defensas o sus objeciones a las demandas en contra de su persona. Sea avisado que si usted no se defiende, la corte tomará medidas y puede continuar la demanda en contra suya sin previo aviso o notificación. Además, la corte puede decidir a favor del demandante y requiere que usted cumpla con todas las provisiones de esta demanda. Usted puede perder dinero o sus propiedades u otros derechos importantes para usted.

LLEVE ESTA DEMANDA A UN ABOGADO INMEDIATAMENTE. SI NO TIENE ABOGADO O SI NO TIENE EL DINERO SUFICIENTE DE PAGAR TAL SERVICIO, VAYA EN PERSONA O LLAME POR TELÉFONO A LA OFICINA CUYA DIRECCIÓN SE ENCUENTRA ESCRITA ABAJO PARA AVERIGUAR DONDE SE PUEDE CONSEGUIR ASISTENCIA LEGAL.

ASOCIACIÓN DE LICENCIADOS DE FILADELFA
SERVICIO DE REFERENCIA E INFORMACIÓN LEGAL
One Reading Center
Filadelfia, Pennsylvania 19107
Teléfono: 215-238-1701

ASSESSMENT OF DAMAGES HEARING IS REQUIRED
JURY TRIAL DEMANDED

RECEIVED MAY - 9 1996

MARKS, FEINER & FRIDKIN, P.C.

BY: MARK S. FRIDKIN

IDENTIFICATION NO. 17462

ATTORNEY FOR Plaintiffs

804 STEPHEN GIRARD BUILDING

21 S. 12th STREET

PHILADELPHIA, PENNSYLVANIA 19107

(215) 563-7888

BRIANNA BOWERMASTER, a minor,
by her parents and natural
guardians, KAREN BOWERMASTER
and WILLIAM BOWERMASTER, and
KAREN BOWERMASTER and WILLIAM
BOWERMASTER in their own right
22 Chester Pike
Ridley Park, PA 19078

vs.

GAILYN THOMAS, M.D.
100 Chester Pike
Ridley Park, PA 19078

and

SUBURBAN ASSOCIATES
100 Chester Pike
Ridley Park, PA 19078

and

CROZER-CHESTER MEDICAL CENTER
15th and Upland Avenues
Upland, PA 19013

Delaware County

COURT OF COMMON PLEAS
CIVIL TRIAL DIVISION

TERM.

No 96-3940

MAJOR JURY

COMPLAINT IN CIVIL ACTION
(Personal Injury - Medical Malpractice)

1. Plaintiff, Brianna Bowermaster, a minor by her parents and natural guardians Karen Bowermaster and William Bowermaster, and Karen Bowermaster and William Bowermaster each in their own right residing at 22 Chester Pike, Ridley Park, PA 19078.

2. Defendant, Gailyn Thomas, M.D., is a medical doctor, licensed to practice medicine in the Commonwealth of Pennsylvania, with offices located at 100 Chester Pike, Ridley Park, PA 19078.

3. Defendant, Suburban Associates, is a medical association, licensed to do business in the Commonwealth of Pennsylvania; with its offices located at 100 Chester Pike, Ridley Park, PA 19078.

4. Defendant, Crozer-Chester Medical Center, is a hospital, open to the public, operated and controlled by the said hospital for treatment of persons injured and sick, for consideration paid to it, located at 15th and Upland Avenues, Upland, PA 19013.

5. At all times material hereto, defendant, Gailyn Thomas, M.D., acted as the agent, servant, and/or employee of defendant, Suburban Associates, or appeared to act as the agent, servant, and/or employee of defendant, Suburban Associates, and was acting within the course and scope of her employment.

6. At all times material hereto, defendant, Gailyn Thomas, M.D., acted as the agent, servant, and/or employee of defendant, Crozer-Chester Medical Center, or appeared to act as the agent, servant, and/or employee of defendant, Crozer-Chester Medical Center, and was acting within the course and scope of her employment.

7. At all times material hereto, defendant, Suburban Associates, acted as the agents, servants, and/or employees of defendant, Crozer-Chester Medical Center, or appeared to act as the agent, servant, and/or workmen of defendant, Crozer-Chester Medical Center, and was acting within the course and scope of their employment.

8. All of the acts alleged to have been done or not to have

been done by the defendants, were done or not done by said defendants, their agents, servants, workmen, and/or employees, acting within the course and scope of their employment with and/or on behalf of said defendants.

9. On or about February 16, 1995, plaintiff, Karen Bowermaster, was a patient of the defendant hospital, Crozer-Chester Medical Center, for the purpose of delivering a baby, minor plaintiff, Brianna Bowermaster, at which time the plaintiffs came under the care of the aforesaid defendant doctor. During delivery of minor plaintiff, Brianna Bowermaster, defendant, Gailyn Thomas, M.D., applied improper techniques causing excessive twisting and force during the course of the delivery. As a result of the negligence, carelessness, and malpractice of the defendants, and each of them, their agents, servants, workmen, and/or employees, the minor plaintiff was caused to suffer severe and permanent injuries as hereinafter more specifically set forth.

10. The negligence, carelessness and malpractice of the defendants, and each of them jointly and/or severally, consisted of the following:

- (a) failing to regard the rights, safety and position of the minor plaintiff;
- (b) failing to observe the standards of skill and care commonly exercised by doctors and hospitals in like circumstances;
- (c) failing to use proper procedures and techniques in the delivery care and treatment of the minor plaintiff;
- (d) failing to properly monitor labor and delivery;
- (e) failing to use the proper techniques during labor and delivery;

(f) using improper twisting and excessive force so as to cause the injuries to minor plaintiff;

(g) causing a humeral fracture to minor plaintiff during delivery;

(h) causing nerve damage to minor plaintiff during delivery;

(i) causing minor plaintiff to suffer Horner's syndrome;

(j) failing to perform an episiotomy and/or a proctoepisiotomy during delivery which was necessary to prevent shoulder dystotia;

(k) failing to make a proper and prompt inquiry into the treatment and care to the minor plaintiff when defendants' carelessness and negligence was or should have been discovered by them;

(l) failing to properly manage plaintiff's shoulder dystocia; and

(m) permitting minor plaintiff to be treated and attended to by incompetent and/or inexperienced medical personnel;

COUNT ONE

BRIANNA BOWERMASTER, a minor, by her parents and natural guardians,
KAREN BOWERMASTER and WILLIAM BOWERMASTER, Plaintiff v. GAILYN
THOMAS and SUBURBAN ASSOCIATES and CROZER CHESTER
HOSPITAL, Defendants

11. Plaintiff, Brianna Bowermaster, a minor by her parents and natural guardians, Karen Bowermaster and William Bowermaster, incorporates by reference all of the averments contained in paragraphs 1 through 10 as fully as though the same were set forth herein at length.

12. As a result of the negligence, carelessness and malpractice of the defendants as aforesaid, the minor plaintiff was

caused to suffer severe and permanent injuries including but not limited to a fractured humerus of the left arm, right shoulder dystocia, brachial plexus injuries, and Horner's syndrome.

13. As a result of the aforesaid, minor plaintiff, Brianna Bowermaster, has undergone great physical pain and mental anguish, and she will continue to endure this pain for an indefinite time in the future to her great detriment and loss, including a loss of life's pleasures.

14. As a result of the negligence, carelessness and malpractice of the defendants as aforesaid, minor plaintiff, Brianna Bowermaster, has, and may, and probably will, be obliged to expend various sums of money for medical care and attention and medicines in and about endeavoring to diagnose, treat, and cure herself of her injuries and disabilities therefrom to her great detriment and loss.

15. As a result of the negligence, carelessness and malpractice of the defendants as aforesaid, minor plaintiff, Brianna Bowermaster, has been unable to attend to her usual daily-duties and occupations, and she may and will be unable to attend to same for an indefinite time in the future, to her great detriment and loss.

COUNT TWO

KAREN BOWERMASTER and WILLIAM BOWERMASTER, in their own right, Plaintiffs v. GAILYN THOMAS, M.D. and SUBURBAN ASSOCIATES and CROZER CHESTER HOSPITAL, Defendants

16. Plaintiffs, Karen Bowermaster and William Bowermaster, in their own right, incorporate by reference all of the averments contained in paragraphs 1 through 15 as fully as though the same were set forth herein at length.

17. By reason of the minor plaintiff's injuries, the earnings

V E R I F I C A T I O N

The undersigned, having read the attached pleading, hereby verifies that the within pleading is based on information furnished to counsel, which information has been gathered by counsel in the course of this lawsuit. The language of the pleading is that of counsel and not of the verifier. Verifier verifies that he/she has read the within pleading and that it is true and correct to the best of verifier's knowledge, information and belief. To the extent that the contents of the within pleading are that of counsel, verifier has relied upon counsel in taking this Verification. If the foregoing contains averments which are inconsistent in fact, verifier has been unable, after reasonable investigation, to ascertain which of the inconsistent averments are true, but verifier has knowledge or information sufficient to form a belief that one of them is true. This Verification is made subject to the penalties of 18 Pa. C.S. 4904, relating to unsworn falsification of authorities.

Karen Gouvenard



FORM A - PLEASE PROVIDE EXPLANATIONS TO SECTION III "YES" ANSWERS ON THIS FORM

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
APPLICATION FOR LICENSURE - PHYSICIAN - MEDICAL DOCTOR, PAGE ONE OF SEVEN

Your Name:

Carlyn B Thomas

MEDICAL MALPRACTICE CLAIM (QUESTION 12) You will need TABLE I on Page 3 to complete this section. Please supply the following information regarding each instance of alleged malpractice: This form should be photocopied and filled out separately for each claim. Additional sheets may be attached if necessary. Please type or print clearly.

Insurer:

PMSLIC

Deborah Gorman-Hitchner and John Flick and

Claimant Name:

Victoria Flick

Description of Alleged Basis(es) of Claim (Allegations Only: This does not constitute an admission of fault or liability.) See Codes on TABLE I, Page 3.

Basis Code:

T 5 5

Basis Code:

T 5 2

Basis Code:

T 5 6

Basis Code:

Additional Descriptive Information - 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; and
- 4) Your degree of responsibility for the course of treatment in leading to the claim.

I saw the patient once postpartum.
She had a failed VBAC attempt
with a ruptured uterus and fetal
distress. I was in a group practice
with the physician primarily
responsible for her pregnancy and
del^{ivery} care
del^{ivery}
Q&A

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

Incident Location (circle one):

01 Emergency Room

05 Outpatient

09 HMO

13 Walk-In Center

02 Labor/Delivery

06 Patient Room

10 Clinic

14 Other _____

03 Laboratory/X-Ray/Testing

07 Hospital-Other

11 Nursing Home

15 Unknown

04 Operating Room

08 Hospital Unknown

12 Physician's Office

Question 12 continued on next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - APPLICATION FOR LICENSURE - PHYSICIAN - MEDICAL DOCTOR, PAGE TWO OF SEVEN

MEDICAL MALPRACTICE CLAIM (QUESTION 12) CONTINUED

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 Compensation Evaluator |
| 06 Surgeon | 16 Court Psychiatrist |
| 07 Fellow | 17 On-Call Physician |
| 08 PGY 1 | 18 Group Practitioner/Partner |
| 09 PGY 2 | 19 Other: Specify _____ |
| 10 PGY 3 | 20 Unknown |

Legal Representative (include name, address and telephone number):

Name: Don Camhi

Firm: Post and Schell, P.C.

Address: 1800 John F. Kennedy Boulevard

City, State, Zip: Phila, PA 19103-7480

Telephone Number: (215) 587-1015

Indicate Decision, Appeal, Settlement, Dismissal:

If a Court or Arbitration Panel heard your case, indicate the following:

Decision determined by (Check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date Appeal Filed (Month, Day, Year) ____/____/____
Date Appeal Decided: ____/____/____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of Settlement: (Month, Day, Year) ____/____/____

☒ Case dismissed against you _____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

Table I for Question 12 on the next page

POST & SCHELL, P.C.
ATTORNEYS AT LAW

1800 JOHN F. KENNEDY BOULEVARD
PHILADELPHIA, PA 19103-7480

(215) 587-1000
FACSIMILE: (215) 587-1444

ADAMS PLACE - SUITE 3
701 WHITE HORSE ROAD
VOORHEES, NJ 08043
(609) 627-8900
FAX: (609) 627-4451

1245 S. CEDAR CREST BOULEVARD
SUITE 300
ALLENTOWN, PA 18103
(610) 433-0193
FAX: (610) 433-3972

237 N. PRINCE STREET
LANCASTER, PA 17603
(717) 291-4532
FAX: (717) 291-1609

240 GRANDVIEW AVENUE
CAMP HILL, PA 17011
(717) 731-1970
FAX: (717) 731-1985

THE BERKSHIRE - SUITE 205
501 WASHINGTON STREET
READING, PA 19603
(610) 375-2258
FAX: (610) 375-2263

February 8, 2000

DONALD N. CAMHI
(215) 587-1015
DCAMHI@POSTSCHELL.COM

FILE NO. 100371

PERSONAL AND CONFIDENTIAL

Gailyn B. Thomas, M.D.
1 Medical Center Boulevard
Pavilion 331
Upland, PA 19013

Re: Flick v. Thomas, M.D., et al

Dear Dr. Thomas :

I am enclosing with this correspondence a copy of a Stipulation of Dismissal as to yourself and Dr. Alderfer which has been signed by all counsel in connection with the above matter. The original of this Stipulation has been filed with the Court.

This formally concludes this case as far as you are concerned. The case will be proceeding against the remaining defendants.

Thank you for your help and cooperation throughout this litigation. Please feel free to contact me with any questions or comments.

Very truly yours,


DONALD N. CAMHI

DNC/rjr

Enc.

cc: Terese Grant, Team Leader - East, PMSLIC
Your File: 333502
(w/enc.)

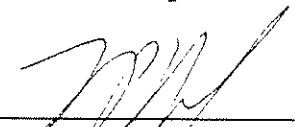
GOLDFEIN & JOSEPH
BY: ROSEANN LYNN BRENNER
ATTORNEY I.D. 39825
1600 Market Street
33rd Floor
Philadelphia, Pa 19103
(215) 979-8200

100371
P.S.
Camhi
APR 31 9:57
PRO PHIL
Attorney for Defendant,
Gill Alderfer, M.D.

DEBORAH GORMAN-HITCHENER and	:	COURT OF COMMON PLEAS
JOHN FLICK, Parents and Natural Guardians	:	PHILADELPHIA COUNTY
of VICTORIA FLICK, a minor, and	:	
DEBORAH GORMAN-HITCHNER and	:	
JOHN FLICK, in their own right	:	APRIL TERM, 1998
	:	
V.	:	
	:	
ALLEGHENY UNIVERSITY HOSPITAL,	:	
HAHNEMANN DIVISION, ET AL	:	NO. 1627

STIPULATION TO DISMISS

It is stipulated and agreed by and between, F. Philip Robin, Esquire, counsel for plaintiffs, Roseann Lynn Brenner, Esquire, counsel for Gill Alderfer, M.D., Donald Camhi, Esquire, counsel for David Ginsberg, M.D. and Gailyn Thomas, M.D. and Cathy Wilson, Esquire, counsel for Allegheny University Hospital and Crozier-Chester Medical Center, that all claims asserted by plaintiffs in this matter as well as all crossclaims asserted by co-defendants against Gill Alderfer, M.D. and Gailyn Thomas, M.D. are hereby dismissed with prejudice.



F. Philip Robin, Esquire



Donald N. Camhi, Esquire



Roseann Lynn Brenner, Esquire



Cathy A. Wilson, Esquire

Præses et Professores
Collegii Medicinæ Pennsylvaniae
ad Instruendum
in Arte Medica Instituti

Omnibus et Singulis has literas lecturis Salutem.

Notum sit quod nos

Hac membrana **Gailyn Brooke Thomas** omnibus studiis
ad gradum Doctoris Medicinæ rite et legitime spectantibus apud nos incubuisse Testamur, eamque coram professoribus
examinatione comprobatum **Doctorem in Arte Medendi** creavimus et constituimus,
eique omnia jura, immunitates et privilegia ad illum gradum hic aut ubique gentium pertinentia dedimus et concessimus.
In cujus rei majorem fidem hoc diploma, communi nostro sigillo munitum et chirographis nostris subscriptum, sit testimonio.

Datum — Annoque Domini 1990 *Philadelphia* Die XIX. Mensis Maii.

This is a true copy *RS*

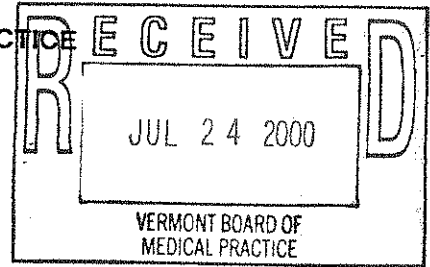
Sworn to and subscribed before me
this 17th day of July 2000.

NOTARIAL SEAL
ADELINE R. ZELESNICK, Notary Public
Upland Boro., Delaware County
My Commission Expires April 20, 2002

Adeline R. Zelesnick

STATE OF VERMONT, BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673

CERTIFICATE OF MEDICAL EDUCATION



To be completed by an officer of your School of Medicine

I hereby certify that Gailyn B Thomas was admitted to the
(Name)

Medical College of Pennsylvania School of Medicine

in Philadelphia, PA on 9-2-1986
(City and State) (Date)

and completed all requirements for graduation on 5-6-1990
(Date)

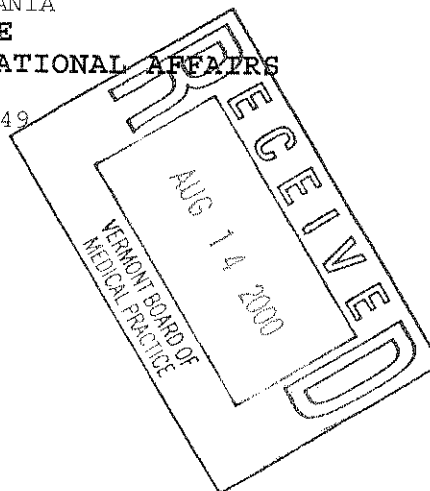
A M.D. Doctor of medicine was granted on 5-19-90
(Specify certificate/diploma/degree) (Date)

(AFFIX SEAL)

Date: July 19, 2000

Signed: Joni A. Simmons
(Authorized Officer of the School)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P.O. BOX 2649
HARRISBURG, PA 17105-2649



AUGUST 09, 2000

GAILYN BROOKE THOMAS
[REDACTED]

STATE BOARD OF MEDICINE

GAILYN BROOKE THOMAS

MEDICAL PHYSICIAN AND SURGEON

TO WHOM IT MAY CONCERN:

THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON IS LICENSED IN THE COMMONWEALTH OF PENNSYLVANIA, DEPARTMENT OF STATE, STATE BOARD OF MEDICINE.

THE RECORDS OF THE PENNSYLVANIA STATE BOARD OF MEDICINE SHOW NO DEROGATORY INFORMATION AGAINST THIS LICENSE.

ORIGINAL LICENSURE DATE: NOVEMBER 16, 1992
EXPIRATION DATE: DECEMBER 31, 2000
LICENSE NUMBER: MD-048663-L


Dorothy Childress
Commissioner

BOARD OF ELECTRICAL EXAMINERS
REAL ESTATE COMMISSION
BOARD OF PILOT COMMISSIONERS
BOARD OF ACCOUNTANCY
REGISTRATION FOR PROFESSIONAL LAND SURVEYORS
BOARD OF ARCHITECTS
BOARD OF CHIROPRACTIC
BOARD OF COSMETOLOGY AND BARBERING
BOARD OF DENTAL EXAMINERS
BOARD OF MEDICAL PRACTICE
BOARD OF NURSING
BOARD OF EXAMINERS IN OPTOMETRY
BOARD OF PHARMACY
BOARD OF PLUMBING EXAMINERS
EXAMINING BOARD OF PHYSICAL THERAPISTS
BOARD OF PODIATRY
ADULT ENTERTAINMENT COMMISSION
COUNCIL ON REAL ESTATE APPRAISERS
GOVERNOR'S MAGISTRATE SCREENING COMMITTEE



STATE OF DELAWARE
DIVISION OF PROFESSIONAL REGULATION
CANNON BUILDING,
861 SILVER LAKE BLVD., STE. 203
DOVER, DELAWARE 19904-2467

BOXING LICENSES
GAMING CONTROL BOARD
BOARD OF GEOLOGISTS
BOARD OF LANDSCAPE ARCHITECTURE
DEADLY WEAPONS DEALERS
BOARD OF EXAMINERS OF PSYCHOLOGISTS
BOARD OF FUNERAL SERVICES
BOARD OF VETERINARY MEDICINE
BOARD OF EXAM. OF NURSING HOME ADMIN.
BOARD OF EXAMINERS OF SPEECH/LANGUAGE
PATHOLOGISTS, AUDIOLOGISTS AND
HEARING AID DISPENSERS
BOARD OF CLINICAL SOCIAL WORK EXAMINERS
BOARD OF PROFESSIONAL COUNSELORS OF
MENTAL HEALTH
BOARD OF OCCUPATIONAL THERAPY
PHYSICIAN ASSISTANT ADVISORY COUNCIL
BOARD OF MASSAGE AND BODYWORK
COMMITTEE OF DIETETICS/NUTRITION
RESPIRATORY CARE PRACTICE ADVISORY COUNCIL

Date: 08/09/00

TELEPHONE: (302) 739-4522
FAX: (302) 739-2711

To: State of Vermont

To Whom It May Concern:

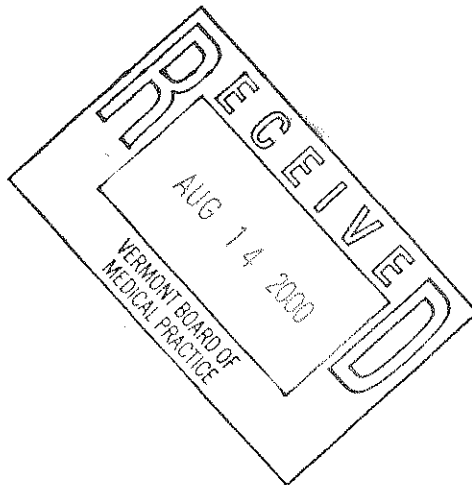
As of 08/09/00, this is to verify that Dr. Gailyn Thomas was issued a license to practice medicine and surgery in the State of Delaware by the Delaware Board of Medical Practice on 08/01/95, License # C1-0004621 which expires on 06/30/99. There is no disciplinary action contained in or pending against the doctor's file.

Please contact us at 302 739-4522 extension 213 for further information.

Sincerely,

Fran Scholl
Investigator

BOARD SEAL





NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)
Endorsement of Certification

This document was prepared by
National Board of Medical Examiners (NBME)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9592

Recipient: Vermont Board of Medical Practice
Licensing & Registration
Redstone Building
26 Terrace Street
Montpelier, VT 05609-1106

Date: 08/03/2000

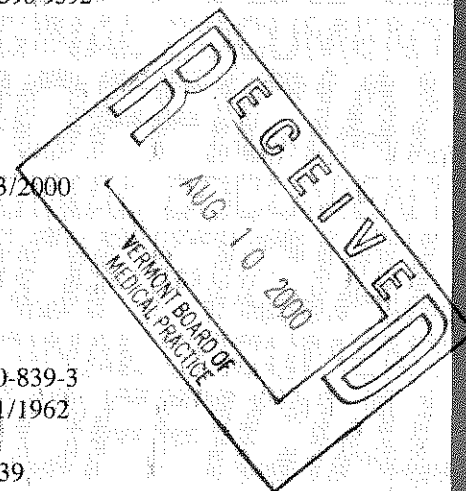
Examinee: Gailyn Brooke Thomas

Examinee ID: 3-390-839-3

Date of Birth: 06/11/1962

NBME Certification Date: 07/01/1991

Certificate#: 390839



It is certified that the physician named above successfully completed the examination, education and training requirements for certification by the NBME as of the certification date shown above. This record shows only passing scores for each NBME Part examination reported on this document. If applicable, results for all USMLE Steps taken by this examinee (and for which scores have been reported to date) are also shown.

NBME PART I

<u>Test Date</u>	<u>Pass/Fail</u>	<u>Score Scale</u>	<u>Total</u>	<u>(Min.Pass)</u>	<u>Individual Subject Scores</u>						
			<u>Score</u>		<u>Anat</u>	<u>Phys</u>	<u>Bioc</u>	<u>Path</u>	<u>Micr</u>	<u>Phar</u>	<u>Beh Sci</u>
06/14/1988	Pass	Three-Digit	450	(380)	415	475	420	470	560	370	510
		Two-Digit	77	(75)	75	79	75	79	84	72	81

NBME PART II

<u>Test Date</u>	<u>Pass/Fail</u>	<u>Score Scale</u>	<u>Total</u>	<u>(Min.Pass)</u>	<u>Individual Subject Scores</u>					
			<u>Score</u>		<u>Med</u>	<u>Surg</u>	<u>ObGyn</u>	<u>Prev</u>	<u>Peds</u>	<u>Psych</u>
09/26/1989	Pass	Three-Digit	460	(290)	420	360	510	475	535	490
		Two-Digit	80	(75)	78	76	82	80	83	81

NBME PART III

<u>Test Date</u>	<u>Pass/Fail</u>	<u>Score Scale</u>	<u>Total</u>	<u>(Min.Pass)</u>
			<u>Score</u>	
03/06/1991	Pass	Three-Digit	515	(290)
		Two-Digit	82	(75)

*** END OF DOCUMENT ***

See reverse side for explanation of information reported above.

VT 1250

Sworn to and subscribed before me
this 11th day of July 2000.

DIPLOMATE

NOTARIAL SEAL
ADELINE R. ZELESNICK, Notary Public
Upland Boro., Delaware County
My Commission Expires April 20, 2002

Adeline R. Zelesnick

American Board of Obstetrics and Gynecology

COMPOSED OF MEMBERS NOMINATED BY THE
AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY
AMERICAN MEDICAL ASSOCIATION
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
ASSOCIATION OF PROFESSORS OF GYNECOLOGY AND OBSTETRICS

Obstetrics and Gynecology

Gailyn Brooke Thomas, M.D.

HAVING PURSUED AN ACCEPTED COURSE OF GRADUATE STUDY AND CLINICAL WORK,
HAS MET THE STANDARDS AND QUALIFICATIONS, AND PASSED THE EXAMINATIONS
REQUIRED BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC.,
AND IS AN ACKNOWLEDGED DIPLOMATE OF THE BOARD
FROM NOVEMBER, 1996 THROUGH DECEMBER, 2006
NOVEMBER 15, 1996



American
Board of
Obstetrics &
Gynecology

Robert C. Caputo
Joseph M. ...
Dean Weiss
William A. ...
Robert ...

DIPLOMATE NO. 743004

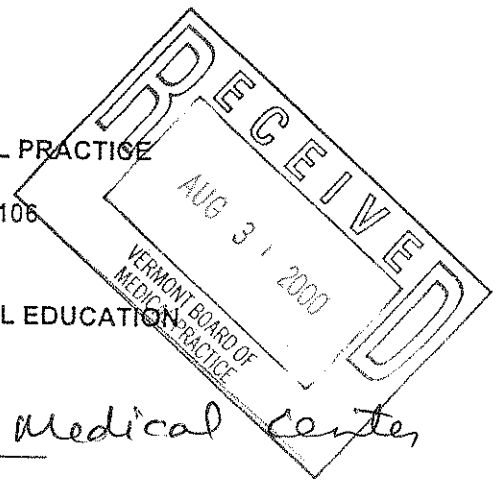
Hayden ...
Dr. H. D. ...
Philip J. ...
Walter C. ...
Ronald S. ...

W. B. ...
Jeff ...
M. ...
Donald K. ...
Edward S. ...



This is a true copy of the original

STATE OF VERMONT, BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673



VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

To be completed by the Training Program Director:

Name of Institution: The Reading Hospital + Medical Center

Address: 6th + Spruce Streets
W. Reading, PA 19612

If name of the Institution was different when applicant attended, please enter name: _____

I hereby certify that Gailyn B. Thomas MD was enrolled in the
Name

residency
Program Type (residency, fellowship)

Obstetrics + Gynecology
Department (e.g. Radiology, Internal Medicine)

at this institution from 6 / 15 / 1990 to
Month Day Year

6 / 23 / 1994
Month Day Year

During the time of the applicant's participation, our postgraduate medical training was accredited by the ACGME. If Canadian Training circle if approved by Royal College of Physicians and Surgeons of Canada.

Our records indicate that the applicant received a certificate of completion on

6 / 23 / 1994
Month Day Year

(AFFIX SEAL)

Date: 8/31/2000

Signed: P. A. Schwartz
(Official of the Sponsoring Institution)

Print Name: P. A. Schwartz

Title: Director, Dept. of Gyn

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673

LIST OF THREE REFERENCES

Detach the attached Reference Forms and send to the individuals designated below* ALONG WITH A COPY OF THE SIGNED FORM B RELEASE. Return this sheet to the Board with your application. Individuals completing the reference forms must return the forms directly to the Board.

*NOTE: Program Director should be substituted for Chief of Service for applicants who are applying for a license while still in residency training or have completed a residency within the last year. (SEE ATTACHED SEPARATE FORM FOR PROGRAM DIRECTOR.)

Names, addresses and telephone numbers of three references:

1) Reference #1 - Chief of Service (See Program Director Note * above): Robert Haggerty
Address: 1098 W Baltimore Pike Suite 3104

City, State, Zip Code: Mediag PA 19063

Telephone: (610) 627-4007

How long and in what capacity has this individual known you? 64RS - colleague/chairman of OB/GYN

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

Name: Olesu Babiala

Address: Dept of anesthesiology
Crozer Chester Medical Center

City, State, Zip Code: Upland PA 19013

Telephone: (610) ~~447~~ 874-6448
error

How long and in what capacity has this individual known you? chairman of anesthesia

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

Name: David Ginsburg

Address: 100 E Chester Pike

City, State, Zip Code: Ridley Park, PA 19078

Telephone: (610) 521 4311

How long and in what capacity has this individual known you? 6yrs - colleague/partner

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

FORM B.

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673

FORM B: 1) AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION
AND 2) AUTHORIZATION TO COMMUNICATE WITH FUTURE EMPLOYERS REGARDING
THE STATUS OF YOUR APPLICATION

TO WHOM IT MAY CONCERN:

1) I, Gailyn B. Thomas, HEREBY AUTHORIZE YOU to furnish to the
(Name of Applicant)

Vermont Board of Medical Practice or its designated representative, all materials and information within your possession or control relating to me, of whatever kind and wherever located and including, but not limited to, my education, my professional experience and qualifications, my licensing history, my practice as a physician, civil and criminal court records, and any other material or information, including investigative files, which, in the sole discretion of the Vermont Board of Medical Practice, may be useful to said Board in its review of my licensing status.

Only in regard to this specific authorization for disclosure to the Vermont Board of Medical Practice and for no other purpose, I expressly WAIVE confidentiality and any privileges or immunities accorded this information by State or Federal Law, and I hold you harmless from disclosure of same to the Vermont Board of Medical Practice.

YOU ARE ALSO AUTHORIZED to report information, either orally or in writing, directly to the Vermont Board of Medical Practice or its designated representative on a continuing basis until this authorization is revoked, by me, in writing.

A CONFORMED PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL SERVE IN ITS STEAD.

2) I further authorize the Vermont Board of Medical Practice to communicate with future employers and/or locum tenens companies regarding the status of my application for licensure.

Signature: Gailyn B. Thomas

Date: 7/7/00

Print or Type Name: Gailyn B Thomas

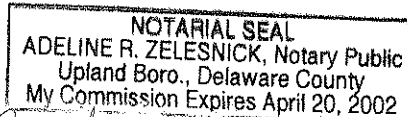
Address: _____

City, State, Zip _____

Telephone Number _____

Subscribed and sworn to before me, this 11th day of July, 2000

Adeline R. Zelesnick
Notary Public



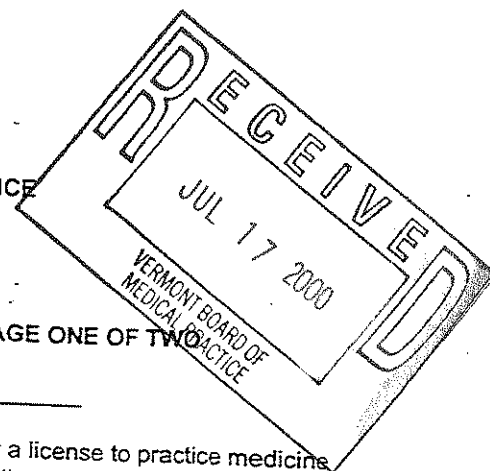
Affix Seal

My License Expires: April 20, 2002

RETURN ORIGINAL TO THE BOARD WITH YOUR APPLICATION
SEND COPIES WITH THE REFERENCE FORMS

Chief of Service Form
Return Directly to Board

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673



REFERENCE FORM TO BE COMPLETED BY CHIEF OF SERVICE, PAGE ONE OF TWO

Name of Applicant: Gailyn B Thomas

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

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

Dr. Thomas was at Crozer Chester Medical Center
from 9/94 to 9/00 and Riddle Memorial Hospital. During that time, he/she was

(List status in the Institution): active / courtesy staff
attending physician OB/GYN

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

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

Chief of Service Form
Continued

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673

REFERENCE FORM TO BE COMPLETED BY CHIEF OF SERVICE, PAGE TWO OF TWO

Name of Applicant: Gailyn B Thomas

How long have you known the applicant and in what capacity? 4 yrs as Peer

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? Yes ☒ Yes ☐ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine? Yes ☒ Yes ☐ No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? Yes ☒ Yes ☐ No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.) Yes ☒ Yes ☐ No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? Yes ☒ Yes ☐ No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? Yes ☒ Yes ☐ No

Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? Yes ☒ Yes ☐ No

Do you know of a failure of the applicant to complete a residency training program(s)? Yes ☒ Yes ☐ No

Does the applicant call upon consultants when needed? Yes ☒ Yes ☐ No

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

The above report is based on:

- ☒ Close personal observation
☐ General impression
☐ A composite of faculty/staff evaluations
☐ Other - Specify: _____

*Gailyn is an excellent OB/GYN Physician
with growing cases for her patients - She displays
Excellent Judgment, Skills & Character*

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

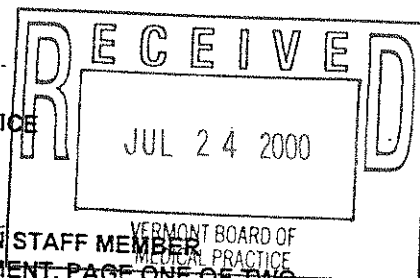
I recommend Gailyn B Thomas MD for licensure in Vermont.
Name of Physician

Signed: [Signature] Date: 7-12-00

Print or Type Name and Title: ROBERT W HAGGERTY, MD CHAIRMAN OB/GYN DEPT
RIDDLE MEMORIAL HOSPITAL
1098 W BALTIMORE PIKE SUITE 3104
MEDIA PA 19063

Reference Form #2
Return Directly to Board

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673



REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN, STAFF MEMBER
AT THE HOSPITAL WHERE YOU HAVE A CURRENT OR RECENT APPOINTMENT, PAGE ONE OF TWO

Name of Applicant: Carolyn B Thomas

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

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

Dr. Thomas was at Crozer Chester Med Center
from 9/94 to 9/00. During that time, he/she was

(List status in the Institution): attending physician & surgeon OB/GYN

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

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

Reference Form #2
Continued

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER
AT THE HOSPITAL WHERE YOU HAVE A CURRENT OR RECENT APPOINTMENT, PAGE TWO OF TWO

Name of Applicant: Gailyn B Thomas

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? ☒ Yes ☐ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine? ☐ Yes ☒ No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? ☐ Yes ☒ No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.) ☐ Yes ☒ No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? ☐ Yes ☒ No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? ☐ Yes ☒ No

Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? ☐ Yes ☒ No

Do you know of a failure of the applicant to complete a residency training program(s)? ☐ Yes ☒ No

Does the applicant call upon consultants when needed? ☒ Yes ☐ No

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

The above report is based on:

- ☒ Close personal observation
☐ General impression
☐ A composite of faculty/staff evaluations
☐ Other - Specify: _____

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

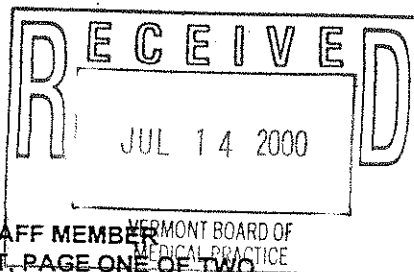
I recommend Gailyn Thomas for licensure in Vermont.
Name of Physician

Signed: [Signature] Date: 2/19/2002

Print or Type Name and Title: Olesh Bablak, M.D.
Dept. of Anesthesiology
604 6965
Chairman

Reference Form #3
Return Directly to Board

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673



REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER
AT THE HOSPITAL WHERE YOU HAVE A CURRENT OR RECENT APPOINTMENT, PAGE ONE OF TWO

Name of Applicant: Gailyn B Thomas

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

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

Dr. Thomas was at Crozer Chester, Riddle Memorial & Taylor Hospital
from 9/94 to 9/00. During that time, he/she was

(List status in the Institution): attending physician OB/GYN

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

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

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER
AT THE HOSPITAL WHERE YOU HAVE A CURRENT OR RECENT APPOINTMENT, PAGE TWO OF TWO

Name of Applicant: Gailyn B Thomas

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? ☒ Yes ☐ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine? ☐ Yes ☒ No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? ☐ Yes ☒ No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.) ☐ Yes ☒ No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? ☐ Yes ☒ No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? ☐ Yes ☒ No

Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? ☐ Yes ☒ No

Do you know of a failure of the applicant to complete a residency training program(s)? ☐ Yes ☒ No

Does the applicant call upon consultants when needed? ☒ Yes ☐ No

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

The above report is based on:

- ☒ Close personal observation
☐ General impression
☐ A composite of faculty/staff evaluations
☐ Other - Specify: _____

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

I recommend Gailyn Thomas MD for licensure in Vermont.
Name of Physician

Signed: David S. Ginsburg MD Date: 7/11/00

Print or Type Name and Title: DAVID S. GINSBURG MD

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

SECTION IV

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

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

☒ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

or

☐ I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

Title 32 § 3113 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 the Department of Taxes. "Good standing" means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

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).

or

☐ I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contributions:

☒ 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 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.)

or

☐ I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.

or

☐ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #

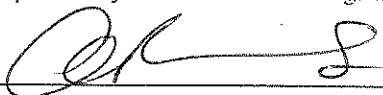
Date of Birth

* 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 by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

STATEMENT OF APPLICANT

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

Signature of Applicant



Date

7/7/00

FORM B

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673

FORM B: 1) AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION
AND 2) AUTHORIZATION TO COMMUNICATE WITH FUTURE EMPLOYERS REGARDING
THE STATUS OF YOUR APPLICATION

TO WHOM IT MAY CONCERN:

1) I, Gailyn B. Thomas, HEREBY AUTHORIZE YOU to furnish to the
(Name of Applicant)

Vermont Board of Medical Practice or its designated representative, all materials and information within your possession or control relating to me, of whatever kind and wherever located and including, but not limited to, my education, my professional experience and qualifications, my licensing history, my practice as a physician, civil and criminal court records, and any other material or information, including investigative files, which, in the sole discretion of the Vermont Board of Medical Practice, may be useful to said Board in its review of my licensing status.

Only in regard to this specific authorization for disclosure to the Vermont Board of Medical Practice and for no other purpose, I expressly WAIVE confidentiality and any privileges or immunities accorded this information by State or Federal Law, and I hold you harmless from disclosure of same to the Vermont Board of Medical Practice.

YOU ARE ALSO AUTHORIZED to report information, either orally or in writing, directly to the Vermont Board of Medical Practice or its designated representative on a continuing basis until this authorization is revoked, by me, in writing.


A CONFORMED PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL SERVE IN ITS STEAD.


2) I further authorize the Vermont Board of Medical Practice to communicate with future employers and/or locum tenens companies regarding the status of my application for licensure.


Signature: Gailyn B. Thomas

Date: 7/7/00

Print or Type Name: Gailyn B Thomas

Address: 

City, State, Zip Code: 

Telephone Number: 

Subscribed and sworn to before me, this 11th day of July, 2000

Adeline R. Zelesnick
Notary Public

NOTARIAL SEAL
ADELINE R. ZELESNICK, Notary Public
Upland Boro., Delaware County
My Commission Expires April 20, 2002

Affix Seal

My License Expires: April 20, 2002

RETURN ORIGINAL TO THE BOARD WITH YOUR APPLICATION
SEND COPIES WITH THE REFERENCE FORMS

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Signature: [Signature]

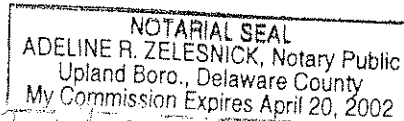
Date: 7/7/00

Print or Type Name: Gailyn B Thomas

Address: [Redacted]
City, State, Zip [Redacted]
Telephone Number [Redacted]

Subscribed and sworn to before me, this 11th day of July, 2000

Adeline R. Zelesnick
Notary Public



Affix Seal

My License Expires: April 20, 2002

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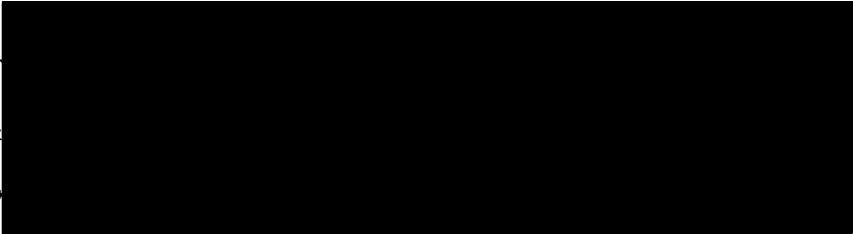
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Signature: Gailyn B. Thomas

Date: 7/7/00

Print or Type Name: Gailyn B Thomas

Address: 

City, State, Zip C

Telephone Number

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Adeline R. Zelesnick
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NOTARIAL SEAL
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SEND COPIES WITH THE REFERENCE FORMS

109 State Street
Montpelier, VT 05609-1106
Tel.: (802) 828-2673
Fax: (802) 828-5450



State of Vermont
Board of Medical Practice

August 1, 2000

Gailyn Brooke Thomas, MD
[REDACTED]

RE: Application for Vermont Medical Licensure

Dear Doctor Thomas:

Your application for licensure in the State of Vermont has been received in this office. It is standard procedure to refer any applicant who answers **"yes"** to one of the application questions to the Board's Licensing Committee before you schedule for your personal interview. Since you have answered **"yes"** to a question on the application, when your file is complete it will be reviewed by the Board's Licensing Committee. If you have not already done so, you will need to provide us with letters from therapists, copies of any malpractice suits, copies of convicted criminal offenses, etc. Whichever applies to the question you answered **"yes"** to.

Unless the Committee requests more information, following the meeting I will inform you of the Board Member to contact for your personal interview.

Also, you will find enclosed your verifications of licensure from Pennsylvania, Delaware and Postgraduate verification from Reading Hospital. These can not be accept from applicants. They must be sent directly to this office from the State Boards and Postgraduate facilities. I have enclosed new forms for you to send to these agencies for completion. Please be sure they are sent directly to this office from them.

If you have any questions in the meantime, please feel free to contact this office at (802) 828-2673.

Sincerely,

A handwritten signature in cursive script, appearing to read "Kim Johnson".

Kim Johnson
Staff Assistant
Vermont Board of Medical Practice

enc.

Renewal - 042.0010144

Name	Gailyn B. Thomas
Credential	042.0010144

Renewal Introduction

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

PHYSICIAN'S LICENSE RENEWAL APPLICATION**PART I**

Please follow the instructions below and submit the completed application with documentation and payment to this office. If you have any questions or need additional information do not hesitate to contact us at 802-657-4220, 800-745-7371 or medicalboard@state.vt.us.

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

INSTRUCTIONS

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

Be sure to submit:

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

Please Note:

- Your Physician License Renewal Application has been pre-populated with information provided by and previously approved by you prior to the initial release of the Department's physician profiles. Please take this opportunity to correct any factual inaccuracies and/or update any information as appropriate.
- Licensees have a continuing obligation during each two-year renewal period to promptly notify the Board of any change or new information including, but not limited to, disciplinary or other action limiting or conditioning their license or ability to practice in any jurisdiction. Failure to do so may subject the licensee to disciplinary action by the Board.

Thank you.

Renewal Part I**Name:**

Indicate your full legal name (use no initials). If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Last Name:
Thomas

2. First Name:
Gailyn

3. Middle Name:

B.

4. Have you ever legally changed your name?

No

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

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

6. Date of Birth:

[REDACTED]

7. Enter your MAILING ADDRESS information:

Attention NVRH

Street 1315 Hospital Drive POB 905

City SAINT
JOHNSBURY

State VT

Zip 05819

Country United
States

E-mail Address

Telephone (802) 748-7300 Alternate Phone (e.g.
Pager)8. Enter your PUBLIC ACCESS address information:

Attention NVRH

Street 1315 Hospital Drive POB 905

City SAINT JOHNSBURY

State VT

Zip 05819

Country United States

Telephone (802) 748-7300

E-mail Address

Alternate Phone (e.g.
Pager)**Renewal Part II**

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

Yes

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

Yes

11. If yes, complete the section below.

State	Profession	License Number	Issue Date	Expiration Date	Status
Pennsylvania	MD	MD 048663L			Inactive
Delaware	MD	C1-0007037			Inactive
Maine	MD	015540			Inactive
New Hampshire	MD	11144			Inactive

12. Medical Professional Schools [26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation.

School	Graduation Date
School Name: MEDICAL COLL. OF PA. State: Pennsylvania Country: School Type: Medical School Degree: MD	01/01/1990

13. Graduate Medical Education/Residency [26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Site Name	End Date	Specialty
Reading Hospital and Medical Center	01/01/1994	Obstetrics and Gynecology

14. Specialty Board Certification [26 VSA § 1368(a)(9)]

Please verify the following information regarding your specialty board certification and update as necessary.

Specialty	Certification Board	Certification Date	Specialty Expiration Date
Obstetrics and Gynecology	American Board of Obstetrics and Gynecology	01/01/1996	

15. Years of Practice

What year did you start practicing as a medical professional?

1994

16. Hospital Privileges [See 26 VSA § 1368(a)(11)]

List all hospitals where you currently have hospital staff privileges:

Facility Name	State	Start Date
NVRH	Vermont	09/01/2010

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

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

No

18. State:

19. Year:

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

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

22. Have you ever withdrawn an application for a certificate to practice medicine or any other healing art?

No

23. State:

24. Year:

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

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

27. 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

28. State:

29. Year:

30. Circumstances:

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

32. 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

33. Name of organization involved:

34. Date:

35. Duration:

36. Action Taken (add all that apply):

37. Circumstances:

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

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

40. State:

41. Year:

42. Circumstances under which examination privileges denied:

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

44. Have you ever discontinued your education, training, or clinical practice for a period of more than three (3) months NOT including premedical education?
No

45. If yes, please explain and include the dates over which your education, training, or clinical practice was discontinued:

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

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

48. Training program(s):

49. Location of program(s):

50. Year:

51. Circumstances:

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

53. 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

54. Institution involved:

55. Location:

56. Year:

57. Circumstances:

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

59. 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

60. Name of organization involved:

61. Type of restriction:

62. Date:

63. Circumstances of restriction

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

65. 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

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

67. Are you presently, or have you ever been, a defendant in a criminal proceeding?
No

68. Court:

69. City and state:

70. Charge:

71. Description:

72. Status:

73. Date:

Renewal Part III**PART III**

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

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

74. To your knowledge, are you 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?

[REDACTED]

75. Licensing or certification board:

76. Date:

77. Location of Licensing Board:

78. Circumstances:

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

MEDICAL DEFINITIONS

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

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make and exercise reasoned medical judgements, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks and procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

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

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

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

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

80. 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?

[REDACTED]

81. 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.

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

83. 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?

[REDACTED]

84. 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.

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

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

[REDACTED]

87. 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.

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

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

89. Treating organization:

90. Address:

91. Telephone:

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

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

94. Dates of treatment (from, to):

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

96. Address:

97. Telephone:

98. Contact person at Program:

CONFIDENTIAL ASSISTANCE IS AVAILABLE

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a service of the Vermont Medical Society. This is a **confidential** program for the identification, treatment and rehabilitation of physicians affected

by the disease of substance abuse. For further information about this program, 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.

99. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] Have you been convicted of any crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets)? For purposes of this question, "convicted" means that you pleaded guilty or that you were found adjudged guilty by a court of competent jurisdiction.

No

100. **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
--------------------	---------------------	------	-------	-------------

101. **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

102. **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
-----------------	-------	------	-------	------------------------

103. **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 stipulations), and/or final disposition of such matters by the courts, if appealed?

No

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

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

Date	Final Disposition Summary
------	---------------------------

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

Have there been any formal charges served against you by licensing or certification authorities of other states?

No

106. **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)]

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

No

108.

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
---------------------	---------------	-------	-----------------------	------------------------

109. 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

110.

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
------	---------------	-------	--------	------------------	--------------------------

111. **Medical Malpractice Court Judgments/Settlements** [See 26 VSA § 1368(a)(6A)] Have you ever been involved in a Malpractice Liability Claim? Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases.

Yes

112.

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

113.

B. Settlements Please provide a description of all settlements of all pending settlements and settlements of medical malpractice claims against you. Please complete the below information and provide copies of papers fully documenting these matters.

Date Of Settlement
12/07/2010

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.**

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.)

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

School	City	State	Nature of Appointment	Year Started	Year Ended
--------	------	-------	-----------------------	--------------	------------

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

School/Institution	City	State	Nature of Teaching	Year Started	Year Ended
--------------------	------	-------	--------------------	--------------	------------

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

Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

Title	Publication	Publication Date
-------	-------------	------------------

117. **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

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

Practice Name	City	State	Primary Practice	Languages	Accepts Medicaid?	Accepts New Medicaid Patients?
Wommen's Wellness	Saint	Utah	Yes		Yes	Yes

Center	Johnsbury					
--------	-----------	--	--	--	--	--

Statement of Good Standing

119.

**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

120. Date:

10/30/2012

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)

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

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

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due and payable and all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan

approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

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

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

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

123. Social Security Number:

[REDACTED]

124. Date of Birth:

[REDACTED]

125. 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

126. Date:

10/30/2012

Renewal Payment

127. 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.

Mail Payment

Review

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

90

2010 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

License Number: 042-0010144

1. Your legal name:

Gailyn B Thomas

a. Have you ever legally changed your name? ___ Yes ☒ No

If yes, enter your former name and any other name(s) under which you were licensed in Vermont or elsewhere in the past two years;

Last Name	First Name	Middle Name:	Suffix
-----------	------------	--------------	--------

b. Indicate your name, as it should appear on your license:

Thomas	Gailyn	B	
Last Name	First Name	Middle Name:	Suffix

2. Your Date of Birth:

[REDACTED]

3. Mailing Address and email address:

Gifford Medical Center OB/GYN
44 Main Street Po Box 2000
RANDOLPH, VT 05060

Northeastern VT Regional Hospital
1315 Hospital Drive Po Box 905
St Johnsbury, VT 05819

4. Work Address:

Gifford Medical Center OB/GYN
44 Main Street Po Box 2000
RANDOLPH, VT 05060

Same

5. Please check your preferred mailing address: ___ Home ☒ Work

NOTE: The mailing address will be publicly listed on the Board's web site.

6. Home Telephone Number with Area Code:

[REDACTED]

7. Work Telephone Number with Area Code: (802) 748-7300

8. E-mail address (if not appearing in #3):

Please check here if the Department of Health may use this e-mail address to send you public health information.

☒ yes ☐ no

PART II

9. Were you in active clinical practice in Vermont in the past 12 Months? ☒ yes ☐ no

10. Do you hold, or have you ever held, a medical license (including temporary) in any other state?

☒ yes ☐ no

If yes, complete the section below and attach additional pages if necessary.

State	License Number	Type of License	Date Issued	Status (Active, inactive, or other, conditioned, restricted, limited)
-------	----------------	-----------------	-------------	---

NH 2000				
ME 2001				
PA 1992				
DE 1995				

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

11. **Medical Professional Schools** [26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation if not listed below.

MEDICAL COLL. OF PA., PA
1990

12. **Graduate Medical Education/Residency** [26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Reading Hospital and Medical Center ,PA
Obstetrics and Gynecology
1994

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

13. **Specialty Board Certification** [26 VSA § 1368(a)(9)]

Please verify the following information regarding your specialty board certification and update as necessary using the attached Specialty Codes List.

Obstetrics and Gynecology
American Board of Obstetrics and Gynecology
1996

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
		<input type="checkbox"/> yes <input type="checkbox"/> no			
		<input type="checkbox"/> yes <input type="checkbox"/> no			

14. **Years of Practice** [26 VSA § 1368(a)(10)]

Month and year you started practicing as a physician? 9//1994

15. **Hospital Privileges** [26 VSA § 1368(a)(11)]

☐ Check here if none

List all information for all hospitals where you currently have hospital staff privileges if not listed below:

~~Gifford Medical Center
Randolph, VT
(2006-Present)~~

*Northeastern VT Regional Hospital
St. Johnsbury, VT 05819
Sept 2010 - present*

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED ON THE ENCLOSED FORM A.

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

☐ yes ☒ no

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

☐ yes ☒ no

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

☐ yes ☒ no

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

☐ yes ☒ no

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

☐ yes ☒ no

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

☐ yes ☒ no

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

☐ yes ☒ no

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

☐ yes ☒ no

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

☐ yes ☒ no

25. 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 ☒ no

26. 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.

27. 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?

[REDACTED]

28. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged?

[REDACTED]

The following definitions are provided to assist you in answering questions 29 through 31.

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

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

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

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

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

29. 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?

[REDACTED]

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.

30. 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?

[REDACTED]

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.

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

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

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 physician profile is located at the following website <http://healthvermont.gov>.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 32 through 37 have changed since your last application. We cannot process your application without them.

32. **Criminal Convictions** [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 ten years not listed below. **Please provide complete copies of documentation for each matter.**

None reported

33. **Nolo Contendere/Matters Continued** [26 VSA § 1368(a)(2)] ☒ Check here if none

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction not listed below. **Please provide complete copies of documentation for each matter.**

None reported

34. **Vermont Board of Medical Practice Matters** [26 VSA § 1368(a)(3)] ☒ Check here if none

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

None reported

35. **Licensing or Certification Authority Matters in Other States** [26 VSA § 1368(a)(4)] ☒ Check here if none

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, if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

36. **Restriction of Hospital Privileges** [26 VSA § 1368(a)(5)]

- A. **Revocation/Involuntary Restrictions** ☒ Check here if none

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 if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

- B. **Other Restrictions** ☒ Check here if none

Please provide a description of all resignations from, or non-renewal 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 if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

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

- A. **Judgments** ☒ 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 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

- B. **Settlements** ☐ Check here if none

Please provide a description of all settlements of medical malpractice claims 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.**

8/31/1999
Delaware County PA
725000
Improper performance of vaginal delivery

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

Note: Answering #38 is optional. By answering, you are granting permission to have this information posted on the web, **exactly as provided to the Board.**

- A. **Appointments** ☒ Check here if none

Please provide information about your appointments to medical school or professional school faculties if not listed.

None reported

B. Teaching

☐ Check here if none

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

University of Vermont
Burlington, VT
Clinical Instructor
2000 - 2003

Hahnemann University
Philadelphia, PA
Assistant Clinical Professor
1994 - 2000

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

☒ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web, exactly as provided to the Board.

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not listed.

40. Activities [26 VSA § 1368(a)(14)]

☐ Check here if none

Note: Answering #40 is optional. By answering, you are granting permission to have this information posted on the web, exactly as provided to the Board.

Please provide information regarding your professional or community service activities and awards if not listed.

May 1990 - The Beatrice Sterling Hollander Memorial Prize awarded for promise of leadership, high character and creativeness in her profession

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

☐ Check here if none

What is the location of your primary practice setting?

~~Randolph, VT~~

St. Johnsbury, VT

42. Translating Services [26 VSA § 1368(a)(16)]

☐ Check here if none

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 here the translating services available:

None

43. Medicaid/New Patients [26 VSA § 1368(a)(17)]

A. Medicaid participation

Do you participate in the Medicaid program?

☒ yes ☐ no

B. New Medicaid Patients

Are you currently accepting new Medicaid patients?

☒ yes ☐ no

Part V

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

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: 9/30/10


Applicant's Signature

Physician Profile Update

26 VSA § 1368 requires the Department to provide you with a copy of your profile prior to the initial release to the public and each time your profile is modified or amended. We intend to use the information in your renewal application for your physician profile.

Please let us know whether you wish to have your profile omit the following information by checking the "OMIT" box below. If the box is not checked, we will include the information in your profile:

OMIT FROM PROFILE

- ☐ Appointments to medical school or professional school faculties, and an indication as to whether you have had a responsibility for teaching graduate medical education within the last 10 years.
- ☐ Information regarding publications in peer-reviewed medical literature within the last 10 years.
- ☐ Information regarding professional or community service activities and awards.

Again, thank you for your cooperation.

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 16 and 17) Withdrawal or denial of License - Attach documents

State _____ Year _____

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

(Question 18) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State _____ Year _____

Circumstances _____

(Question 19) Disciplinary charges or action - Attach documents

Name of organization involved _____ Date _____

Duration _____

Action taken (circle all that apply)

- | | |
|---|---|
| 01 Revocation of right or privilege | 12 Leave of absence |
| 02 Suspension of right or privilege | 13 Withdrawal of an application |
| 03 Censure | 14 Termination or non-renewal of contract |
| 04 Written reprimand or admonition | 15 Medical Records Suspension |
| 05 Restriction of right or privilege | 16 Probation |
| 06 Non-renewal of right or privilege | 17 Assurance of 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) _____ |

Circumstances _____

(Question 20) Denial of examination privileges - Attach documents

State _____ Year _____

Circumstances under which examination privileges denied _____

(Questions 21 and 22) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

(Question 23) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances _____

(Question 24) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

(Question 25) Internet prescribing

Please provide a general description of your practice of internet prescribing

(Questions 26 and 28) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

Status _____

Conviction? ____ Yes ____ No Date _____

Plea? ____ Yes ____ No Date _____

(Question 27) Investigation by any other licensing board - Attach documents

Name of Licensing Board _____ Date _____

Location of Licensing Board _____

Circumstances _____

(Questions 29-30) Medical condition, treatment, use of chemical or illegal substances

Treating organization _____

Address _____ Telephone _____

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

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____ Telephone _____

Contact person at Program _____

(Question 37) Medical Malpractice Claim

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.

Insurer _____

Claimant name _____

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

Please indicate:

1. Patient's condition at point of your involvement;
2. Patient's condition at end of treatment;
3. The nature and extent of your involvement with the patient;
4. Your degree of responsibility for the course of treatment in leading to the claim; and
5. Narrative of event.

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

Your role (circle one):

- | | |
|---------------------------|-------------------------------------|
| 01 Anesthesiologist | 11 PGY 4 |
| 02 Primary Care Physician | 12 PGY 5 |
| 03 Referring Physician | 13 PGY 6 |
| 04 Attending Physician | 14 PGY 7 |
| 05 Consultant Specialist | 15 Workmen's Compensation Evaluator |
| 06 Surgeon | 16 Court Psychiatrist |
| 07 Fellow | 17 On-Call Physician |
| 08 PGY 1 | 18 Group Practitioner/Partner |
| 09 PGY 2 | 19 Other: Specify _____ |
| 10 PGY 3 | 20 Unknown |

Your Legal Representative in this matter (include name, address and telephone number)

Name _____

Firm _____

Address _____

City, State, Zip _____

Phone _____

Indicate Decision, Appeal, Settlement, Dismissal:

If a Court or Arbitration Panel heard your case, indicate the following:

Court _____

Court's location _____

Docket number _____

Date the action was filed _____

Decision determined by (check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date appeal filed (month, day, year)

_____/_____/_____
Date appeal decided: (month, day, year) ____/____/____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of settlement: (month, day, year) ____/____/____

_____ Case dismissed against you _____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

VERMONT'S PRESCRIPTION CONFIDENTIALITY LAW
Prescriber Data-Sharing Program

CONSENT FORM

Under Vermont's Act 80, a law passed in 2007, pharmaceutical companies may not use information that identifies prescribers in prescription drug records for marketing or promoting prescription drugs unless the prescriber consents. The text of the law, which took effect July 1, 2009, is found at 18 V.S.A. § 4631. The Vermont Attorney General has links to the statute and further information about the implementation of this law on the website. Go to <http://www.atg.state.vt.us/> and follow the link for Prescribed Products and then look for information on Prescription Confidentiality.

If you wish, you may permit your identifying information in drug prescription records to be used for marketing and promoting of prescription drugs. The only way to grant permission is by giving your consent in the manner described below. If you do not consent, your identifying information from prescription drug records cannot be used for marketing or promoting prescription drugs.

The list of everyone who has a current consent on file with their licensing board, as well as consent and revocation forms are available online at: http://healthvermont.gov/hc/med_board/bmp.aspx. You may check this site at any time to confirm your status. If you consent, your consent is effective until you revoke your consent. **If you wish to make a change, you may download consent and revocation forms at the web address above. If you do not have web access, you may contact your licensing board for assistance.**

How to consent: If you want to consent to the use of your information for marketing and promoting prescription drugs, sign your name, complete the form, and return it as part of your license application or license renewal. If you consent, your name will be included on the list of Vermont prescribers who have consented, and your information may be used for marketing and promoting prescription drugs. You may also complete this form at any time and mail it to your licensing board.

If you do not consent: If you do not wish your identifying information in prescription drug records to be used for marketing or promoting prescription drugs, you need do nothing.

If you choose not to consent, please leave this form blank.

To consent, sign, date, and fill out the form below. Return the completed form with your license application or license renewal or mail the form to **Board of Medical Practice, PO Box 70, Burlington, VT 045470-0070.**

I consent:

Signature Date

Name (printed or typed)

License type (profession) Vermont License Number

Mailing Address

City, State, Zip

VERMONT'S PRESCRIPTION CONFIDENTIALITY LAW
Prescriber Data-Sharing Program

REVOCATION OF CONSENT FORM

If at any time a prescriber wishes to revoke his or her consent to use of prescriber identifiable drug information, the revocation must occur using this form.

I _____ (**print name**) hereby **revoke** my consent to the use of regulated records which include prescription information containing my prescriber-identifiable data for the purpose of marketing or promoting a prescription drug.

Signature

Date

Name (printed or typed)

License type (profession)

Vermont License Number

Mailing Address

City, State, Zip

Please mail your completed form to:

Board of Medical Practice
Vermont Department of Health
PO Box 70
Burlington, VT 05402-0070

State of Vermont
Department of Health
Board of Medical Practice

Statement of Good Standing

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

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

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

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

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

Signature:  Date: 9/30/10

PLEASE NOTE:

In accordance with 4 V.S.A. §1110 (b), you must sign, date, and return this **Statement of Good Standing** in order for us to renew your license. Thank you.

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

You must answer questions 1, 2, and 3.

Regarding Child Support

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

1. You must check one of the two statements below regarding child support regardless whether or not you have children:
- ☒ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.
- or
- ☐ I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application 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 all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

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).
- or
- ☐ I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment 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.)
- or
- ☐ I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
- or
- ☐ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #

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 by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

STATEMENT OF APPLICANT

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

Signature of Applicant

Date

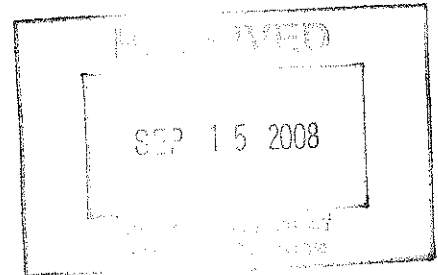
VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070
802 657-4220 or 800-745-7371

2008

2008 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

License Number: 042-0010144



1. Your legal name:

Gailyn B Thomas

a. Have you ever legally changed your name? ___ Yes ☒ No

If yes, enter your former name and any other name(s) under which you were licensed in Vermont or elsewhere in the past two years;

_____	_____	_____	_____
Last Name	First Name	Middle Name:	Suffix

b. Indicate your name, as it should appear on your license:

_____	_____	_____	_____
Last Name	First Name	Middle Name:	Suffix

2. Your Date of Birth: [REDACTED]

3. Home Address and email address:

Gifford Medical Center OB/GYN
44 Main Street PoBox 2000
RANDOLPH, VT 05060

4. Work Address:

Gifford Medical Center OB/GYN
44 Main Street PoBox 2000
RANDOLPH, VT 05060

5. Please check your preferred mailing address: ___ Home ☒ Work

NOTE: The mailing address will be publicly listed on the Board's web site.

6. Home Telephone Number with Area Code: [REDACTED]

7. Work Telephone Number with Area Code: (802) 728-2401

8. E-mail address (if not appearing in #3):

Please check here if the Department of Health may use this e-mail address to send you public health information.

☐ yes ☐ no

PART II

9. Were you in active clinical practice in Vermont in the past 12 Months? ☒ yes ☐ no

10. Do you hold, or have you ever held, a medical license (including temporary) in any other state?
☒ yes ☐ no

If yes, complete the section below and attach additional pages if necessary.

State	License Number	Type of License	Date Issued	Status (Active, Inactive, or other, conditioned, restricted, limited)
	NH 2000			<i>inactive</i>
	ME 2001			<i>inactive</i>
	PA 1992			<i>inactive</i>
	DE 1995			<i>inactive</i>

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

11. **Medical Professional Schools** [26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation if not listed below.

MEDICAL COLL. OF PA., PA
1990

12. **Graduate Medical Education/Residency** [26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Reading Hospital and Medical Center ,PA
Obstetrics and Gynecology
1994

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

13. **Specialty Board Certification** [26 VSA § 1368(a)(9)]

Please verify the following information regarding your specialty board certification and update as necessary using the attached Specialty Codes List.

Obstetrics and Gynecology
American Board of Obstetrics and Gynecology
1996

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
		<input type="checkbox"/> yes <input type="checkbox"/> no			
		<input type="checkbox"/> yes <input type="checkbox"/> no			

14. **Years of Practice** [26 VSA § 1368(a)(10)]

Month and year you started practicing as a physician? 9//1994

15. Hospital Privileges [26 VSA § 1368(a)(11)]

☐ Check here if none

List all information for all hospitals where you currently have hospital staff privileges if not listed below:

~~Christiana Care Health System
Newark, DE
(2005-)~~

Gifford Medical Center
44 S. Main Street
Randolph, VT 05060
2006 - present

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED ON THE ENCLOSED FORM A.

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

☐ yes ☒ no

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

☐ yes ☒ no

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

☐ yes ☒ no

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

☐ yes ☒ no

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

☐ yes ☒ no

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

☐ yes ☒ no

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

☐ yes ☒ no

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

☐ yes ☒ no

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

☐ yes ☒ no

25. Do you currently or have you ever prescribed any prescription medication over the internet?

☐ yes ☒ no

26. 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.

27. 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?

[REDACTED]

28. To your knowledge, are you presently the subject of a criminal investigation under which you have not been charged?

[REDACTED]

The following definitions are provided to assist you in answering questions 29 through 31.

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

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

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

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

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

29. 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?

[REDACTED]

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.

30. 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?

[REDACTED]

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.

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

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

PART IV

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 physician profile is located at the following website <http://healthvermont.gov>.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 32 through 37 have changed since your last application. We cannot process your application without them.

32. **Criminal Convictions** [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 ten years not listed below. **Please provide complete copies of documentation for each matter.**

None reported

33. **Nolo Contendere/Matters Continued** [26 VSA § 1368(a)(2)] ☒ Check here if none

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction not listed below. **Please provide complete copies of documentation for each matter.**

None reported

34. **Vermont Board of Medical Practice Matters** [26 VSA § 1368(a)(3)] ☒ Check here if none

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

None reported

35. **Licensing or Certification Authority Matters in Other States** [26 VSA § 1368(a)(4)] ☒ Check here if none

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, if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

36. **Restriction of Hospital Privileges** [26 VSA § 1368(a)(5)]

A. **Revocation/Involuntary Restrictions**

☒ Check here if none

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 if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

B. **Other Restrictions**

☒ Check here if none

Please provide a description of all resignations from, or non-renewal 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 if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

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

A. **Judgments**

☒ 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 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

B. **Settlements**

☐ Check here if none

Please provide a description of all settlements of medical malpractice claims 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.**

8/31/1999

Delaware County PA

725000

Improper performance of vaginal delivery

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

Note: Answering #38 is optional. By answering, you are granting permission to have this information posted on the web, **exactly as provided to the Board.**

A. **Appointments**

☒ Check here if none

Please provide information about your appointments to medical school or professional school faculties if not listed.

None reported

B. Teaching

☐ Check here if none

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

University of Vermont
Burlington, VT
Clinical Instructor
~~2001 - present~~ 2000 - 2003

Hahnemann University
Philadelphia, PA
Assistant Clinical Professor
1994 - 2000

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

☒ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web, exactly as provided to the Board.

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not listed.

40. Activities [26 VSA § 1368(a)(14)]

☐ Check here if none

Note: Answering #40 is optional. By answering, you are granting permission to have this information posted on the web, exactly as provided to the Board.

Please provide information regarding your professional or community service activities and awards if not listed.

May 1990 - The Beatrice Sterling Hollander Memorial Prize %22awarded for promise of leadership, high character and creativeness in her profession%22

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

☐ Check here if none

What is the location of your primary practice setting?

BURLINGTON, VT

Randolph, VT

42. Translating Services [26 VSA § 1368(a)(16)]

☒ Check here if none

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 here the translating services available:

None

43. Medicaid/New Patients [26 VSA § 1368(a)(17)]

A. Medicaid participation

Do you participate in the Medicaid program?

☒ yes ☐ no

B. New Medicaid Patients

Are you currently accepting new Medicaid patients?

☒ yes ☐ no

Part V

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

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: _____

9/6/08



Applicant's Signature

Physician Profile Update

26 VSA § 1368 requires the Department to provide you with a copy of your profile prior to the initial release to the public and each time your profile is modified or amended. We intend to use the information in your renewal application for your physician profile.

Please let us know whether you wish to have your profile omit the following information by checking the "OMIT" box below. If the box is not checked, we will include the information in your profile:

OMIT FROM PROFILE

- ☐ Appointments to medical school or professional school faculties, and an indication as to whether you have had a responsibility for teaching graduate medical education within the last 10 years.
- ☒ Information regarding publications in peer-reviewed medical literature within the last 10 years.
- ☐ Information regarding professional or community service activities and awards.

Again, thank you for your cooperation.

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 one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

1. You must check one of the two statements below regarding child support regardless whether or not you have children:
- ☒ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.
- or
- ☐ I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application 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 all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

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).
- or
- ☐ I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment 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.)
- or
- ☐ I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
- or
- ☐ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

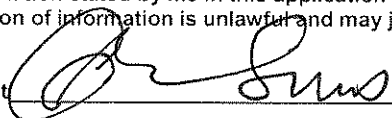
Social Security # [REDACTED] Date of Birth [REDACTED]

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

STATEMENT OF APPLICANT

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

Signature of Applicant



Date

9/18/08

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.

Date: 9/5/08



PLEASE NOTE:

In accordance with 4 V.S.A. § 1110 (b), you must sign, date, and return this **Statement of Good Standing** in order for us to renew your license. Thank you.

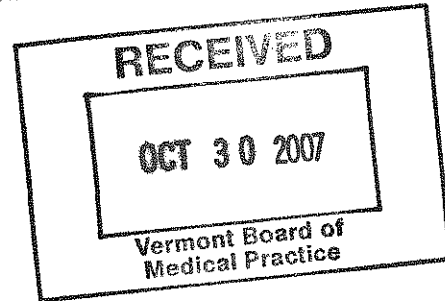


THOMAS A. MUSI, JR.
WILLIAM E. MALONE, JR.
RICHARD C. DAUBENBERGER
STEVEN M. PACILLO
C. CURTIS NORCINI

JENNIFER A. LATOUR
ANGELA M. YAHNER
JONATHAN D. CONSADENE
AMANDA L. JOACHIM

October 26, 2007

Office of Professional Regulation
National Life Building
North FL2
Montpelier, VT 05620-3402



RE: Debora Dunbar v. Gailyn Thomas
IN SUPPORT
PACSES Case Number 392107036

To Whom It May Concern:

Please be advised that I represent the obligor, Dr. Gailyn Thomas, in the above-referenced matter that is currently pending in the Delaware County Court of Common Pleas in the Commonwealth of Pennsylvania. My client has recently advised me that the opposing party, Ms. Dunbar, has threatened to send correspondence to your attention alleging that Dr. Thomas has been dishonest in explaining why she was unable to appear for a modification conference on August 1, 2007.

By way of brief background, Dr. Thomas was unable to appear for said conference because she was notified shortly before the conference that due to the absence of one of her medical partners, Dr. Thomas was required to cover both office and inpatient services from 8:00 a.m. until 8:00 p.m. on the date of the conference. As an attending physician, Dr. Thomas's responsibilities include being physically present to manage surgical emergencies. This was verified through correspondence from Dr. Thomas's employer, Gifford Medical Center, which was forwarded to Ms. Dunbar's attorney by my office.

Ms. Dunbar apparently feels, without any basis, that said correspondence contains untruths and has disclosed that belief to the author of said correspondence. Ms. Dunbar has also threatened to notify your office, as well as the Vermont State Board of Medical Practice, of her belief as well in apparent attempt to discredit Dr. Thomas by your calling attention to this matter.

Please be advised that it is my belief, as well as my client's, that this is a domestic relations matter that should be addressed solely by the Domestic Relations Section of the Delaware County Court of Common Pleas and thus does not require your attention. Further, Ms. Dunbar's claims are simply baseless as Dr. Thomas's obligations and reason

MUSI, MALONE & DAUBENBERGER, L.L.P.

ATTORNEYS AT LAW

1818 MARKET ST., SUITE 2300
PHILADELPHIA, PA 19103
215.940.8806

21 WEST THIRD ST., MEDIA, PA 19063
TEL.: 610.891.8806 FAX.: 610.891.8807

310 NORTH HIGH ST.
WEST CHESTER, PA 19380
610.692.8806

Office of Professional Regulation
October 26, 2007
Page 2

for not attending said conference were verified through written correspondence from her employer. Additionally, I appeared at said conference on Dr. Thomas's behalf in her absence and obtained a continuance that was approved by the Court.

Therefore, if Ms. Dunbar does in fact submit correspondence to you regarding this matter, I am respectfully requesting that you honor my client's wishes and ignore same as being simply irrelevant, as it is outside of your jurisdiction, and baseless, as Dr. Thomas's reason for not attending said conference were verified by her employer. If you have any questions or concerns please do not hesitate to contact me.

Thank you for your kind attention to the above.

Sincerely,

A handwritten signature in black ink, appearing to read "Thomas A. Musi, Jr.", with a stylized, cursive script.

Thomas A. Musi, Jr.

TAM/lac

cc: Dr. Gailyn Thomas

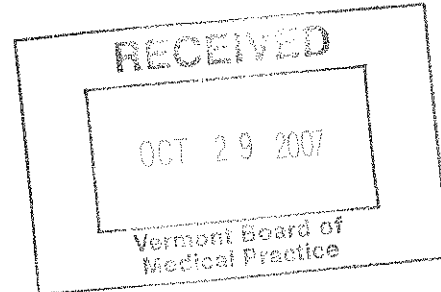


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JENNIFER A. LATOUR
ANGELA M. YAHNER
JONATHAN D. CONSADENE
AMANDA L. JOACHIM

October 26, 2007

Vermont State Board of Medical Practice
Vermont Department of Health
108 Cherry Street
Burlington, VT 05402



RE: Debora Dunbar v. Gailyn Thomas
IN SUPPORT
PACSES Case Number 392107036

To Whom It May Concern:

Please be advised that I represent the obligor, Dr. Gailyn Thomas, in the above-referenced matter that is currently pending in the Delaware County Court of Common Pleas in the Commonwealth of Pennsylvania. My client has recently advised me that the opposing party, Ms. Dunbar, has threatened to send correspondence to your attention alleging that Dr. Thomas has been dishonest in explaining why she was unable to appear for a modification conference on August 1, 2007.

By way of brief background, Dr. Thomas was unable to appear for said conference because she was notified shortly before the conference that due to the absence of one of her medical partners, Dr. Thomas was required to cover both office and inpatient services from 8:00 a.m. until 8:00 p.m. on the date of the conference. As an attending physician, Dr. Thomas's responsibilities include being physically present to manage surgical emergencies. This was verified through correspondence from Dr. Thomas's employer, Gifford Medical Center, which was forwarded to Ms. Dunbar's attorney by my office.

Ms. Dunbar apparently feels, without any basis, that said correspondence contains untruths and has disclosed that belief to the author of said correspondence. Ms. Dunbar has also threatened to notify your office, as well as the Office of Professional Regulation, of her belief as well in apparent attempt to discredit Dr. Thomas by your calling attention to this matter.

Please be advised that it is my belief, as well as my client's, that this is a domestic relations matter that should be addressed solely by the Domestic Relations Section of the Delaware County Court of Common Pleas and thus does not require your attention. Further, Ms. Dunbar's claims are simply baseless as Dr. Thomas's obligations and reason

MUSI, MALONE & DAUBENBERGER, L.L.P.

ATTORNEYS AT LAW

1818 MARKET ST., SUITE 2300
PHILADELPHIA, PA 19103
215.940.8806

21 WEST THIRD ST., MEDIA, PA 19063
TEL.: 610.891.8806 FAX.: 610.891.8807

310 NORTH HIGH ST.
WEST CHESTER, PA 19380
610.692.8806


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for not attending said conference were verified through written correspondence from her employer. Additionally, I appeared at said conference on Dr. Thomas's behalf in her absence and obtained a continuance that was approved by the Court.

Therefore, if Ms. Dunbar does in fact submit correspondence to you regarding this matter, I am respectfully requesting that you honor my client's wishes and ignore same as being simply irrelevant, as it is outside of your jurisdiction, and baseless, as Dr. Thomas's reason for not attending said conference were verified by her employer. If you have any questions or concerns please do not hesitate to contact me.

Thank you for your kind attention to the above.

Sincerely,



Thomas A. Musi, Jr.

TAM/lac

cc: Dr. Gailyn Thomas

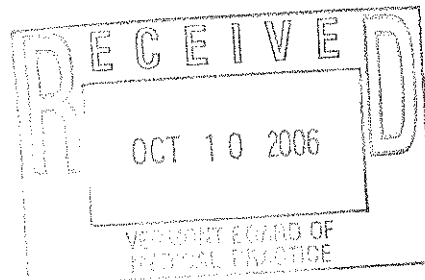
VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070
802 657-4220 or 800-745-7371

PO
492.00

2006 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

License Number: 042-0010144



1. Your legal name:

Gailyn B Thomas

a. Have you ever legally changed your name? ___ Yes ☒ No

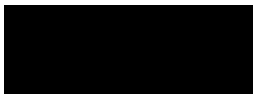
If yes, enter your former name and any other name(s) under which you were licensed in Vermont or elsewhere in the past two years;

Last Name First Name Middle Name: Suffix

b. Indicate your name, as it should appear on your license:

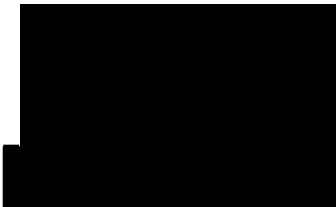
Gailyn Thomas, Gailyn Brooke M.D.
Last Name First Name Middle Name: Suffix

2. Your Date of Birth:



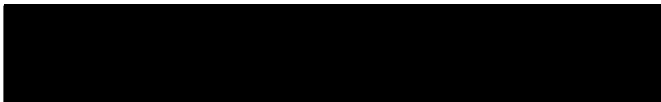
3. Home Address and email address:

Gifford Medical Center OB/GYN
44 Main Street PoBox 2000
RANDOLPH, VT 05060



4. Work Address:

Gifford Medical Center OB/GYN
44 Main Street PoBox 2000
RANDOLPH, VT 05060



5. Please check your preferred mailing address: ___ Home ☒ Work

NOTE: The mailing address will be publicly listed on the Board's web site.

6. Home Telephone Number with Area Code:



7. Work Telephone Number with Area Code: (802) 728-2472

8. E-mail address (if not appearing in #3):



Please check here if the Department of Health may use this e-mail address to send you public health information.

☒ yes ☐ no

PART II

9. Were you in active practice in Vermont in the past 12 Months? ☒ yes ☐ no

10. Do you hold, or have you ever held, a medical license (including temporary) in any other state?

☒ yes ☐ no

If yes, complete the section below and attach additional pages if necessary.

State	License Number	Type of License	Date Issued	Status (Active, Inactive, or other, e.g. conditioned, restricted, limited)
NH 2000	11144	physician	12/6/00	inactive
ME 2001	015540	physician	2001	inactive
PA 1992	MD048663L	physician	1992	active
DE 1995	CI-0007037	physician	1995	active

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED ON THE ENCLOSED FORM A.

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

☐ yes ☒ no

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

☐ yes ☒ no

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

☐ yes ☒ no

14. 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

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

☐ yes ☒ no

16. 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

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

☐ yes ☒ no

18. 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

19. 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

20. 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.

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

[REDACTED]

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

[REDACTED]

The following definitions are provided to assist you in answering questions 23 through 25.

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

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

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

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

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

23. 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?

[REDACTED]

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.

24. 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.

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

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

PART IV

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 physician profile is located at the following website <http://healthvermont.gov>.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 26 through 31 have changed since your last application. We cannot process your application without them.

26. **Criminal Convictions** [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 ten years not listed below. **Please provide complete copies of documentation for each matter.**

None reported

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

27. **Nolo Contendere/Matters Continued** [26 VSA § 1368(a)(2)] ☒ Check here if none

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction not listed below. **Please provide complete copies of documentation for each matter.**

None reported

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

28. **Vermont Board of Medical Practice Matters** [26 VSA § 1368(a)(3)] ☒ Check here if none

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

None reported

(Date)

(Final Disposition - Summary)

29. Licensing or Certification Authority Matters in Other States [26 VSA § 1368(a)(4)]

☒ Check here if none

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, if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

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

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

A. Revocation/Involuntary Restrictions

☒ Check here if none

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 if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

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

B. Other Restrictions

☒ Check here if none

Please provide a description of all resignations from, or non-renewal 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 if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

(Date) (Hospital) (State)

(Nature of Action) (Action)

☐ In lieu

☐ In settlement

(Reason for Action)

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

A. Judgments

☒ Check here if none

AS
10/16/06

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

☐ Judgement ☐ Arbitration

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

B. Settlements

☐ Check here if none

Please provide a description of all settlements of medical malpractice claims 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.**

8/31/1999
Delaware County PA
725000
Improper performance of vaginal delivery

(Date)	(Court)	(State)	(Amount of Settlement Against You)
--------	---------	---------	------------------------------------

32. Medical Professional Schools [26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation if not listed below.

MEDICAL COLL. OF PA., PA
1990

33. Graduate Medical Education/Residency [26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Reading Hospital and Medical Center ,PA
Obstetrics and Gynecology
1994

(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation)
----------------------	-------------	--------	---------	----------------------

(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation)
----------------------	-------------	--------	---------	----------------------

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

34. Specialty Board Certification [26 VSA § 1368(a)(9)]

Please verify the following information regarding your specialty board certification and update as necessary using the attached Specialty Codes List.

Obstetrics and Gynecology
American Board of Obstetrics and Gynecology
1996

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
		<input type="checkbox"/> yes <input type="checkbox"/> no			
		<input type="checkbox"/> yes <input type="checkbox"/> no			

35. **Years of Practice** [26 VSA § 1368(a)(10)]

Month and year you started practicing as a physician? **9/1994**

36. **Hospital Privileges** [26 VSA § 1368(a)(11)]

☐ Check here if none

List all information for all hospitals where you currently have hospital staff privileges if not listed below:

~~Christiana Care Health System~~
~~Newark, DE~~
~~(2005-)~~

Gifford Medical Center Randolph, VT 2006
(Name) (City) (State) (Year Started)

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

Note: Answering #37 is optional. By answering, you are granting permission to have this information posted on the web, exactly as provided to the Board.

A. **Appointments**

☐ Check here if none

Please provide information about your appointments to medical school or professional school faculties if not listed.

University of Vermont
Burlington, VT
Clinical Instructor
2001 - present 2004

Hahnemann University
Philadelphia, PA
Assistant Clinical Professor
1994 - 2000

(School) (City) (State) (Nature of Appointment) From (year) To (year)

B. **Teaching**

☐ Check here if none

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

University of Vermont
Burlington, VT

Clinical Instructor
2001 - ~~present~~ 2004

Hahnemann University
Philadelphia, PA
Assistant Clinical Professor
1994 - 2000

(School/Institution) (City) (State) (Nature of Teaching) From (year) To (year)

38. **Publications:** [26 VSA § 1368(a)(13)] ☒ Check here if none

Note: Answering #38 is optional. By answering, you are granting permission to have this information posted on the web, **exactly as provided to the Board.**

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not listed.

(Title) (Publication) (Year)

(Title) (Publication) (Year)

(Title) (Publication) (Year)

39. **Activities** [26 VSA § 1368(a)(14)] ☐ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web, **exactly as provided to the Board.**

Please provide information regarding your professional or community service activities and awards if not listed.

May 1990 - The Beatrice Sterling Hollander Memorial Prize %22awarded for promise of leadership, high character and creativeness in her profession%22

(Activities or Awards)

(Activities or Awards)

(Activities or Awards)

40. **Practice Setting** [26 VSA § 1368(a)(15)] ☐ Check here if none

What is the location of your primary practice setting? ~~BURLINGTON, VT~~ Randolph, UT

41. **Translating Services** [26 VSA § 1368(a)(16)] ☒ Check here if none

Please identify any translating services available at your primary practice location.

Are any translating services available at your primary practice location? ☐ Not applicable

If yes, please describe here the translating services available:

None

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

42. **Medicaid/New Patients** [26 VSA § 1368(a)(17)]

A. **Medicaid participation**

Do you participate in the Medicaid program? ☒ yes ☐ no ☐ not applicable

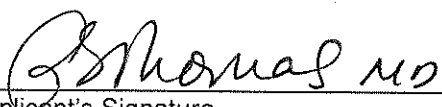
B. **New Medicaid Patients**

Are you currently accepting new Medicaid patients? ☒ yes ☐ no ☐ not applicable

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: 10/2/06


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

Physician Profile Update

26 VSA § 1368 requires the Department to provide you with a copy of your profile prior to the initial release to the public and each time your profile is modified or amended. We intend to use the information in your renewal application for your physician profile.

Please let us know whether you wish to have your profile omit the following information by checking the "OMIT" box below. If the box is not checked, we will include the information in your profile:

OMIT FROM PROFILE

- ☒ Appointments to medical school or professional school faculties, and an indication as to whether you have had a responsibility for teaching graduate medical education within the last 10 years.
- ☒ Information regarding publications in peer-reviewed medical literature within the last 10 years.
- ☒ Information regarding professional or community service activities and awards.

Again, thank you for your cooperation.

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 11 and 12) Withdrawal or denial of License - Attach documents

State _____ Year _____

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

(Question 13) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State _____ Year _____

Circumstances _____

(Question 14) Disciplinary charges or action - Attach documents

Name of organization involved _____ Date _____

Duration _____

Action taken (circle all that apply)

- | | |
|---|---|
| 01 Revocation of right or privilege | 12 Leave of absence |
| 02 Suspension of right or privilege | 13 Withdrawal of an application |
| 03 Censure | 14 Termination or non-renewal of contract |
| 04 Written reprimand or admonition | 15 Medical Records Suspension |
| 05 Restriction of right or privilege | 16 Probation |
| 06 Non-renewal of right or privilege | 17 Assurance of 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) _____ |

Circumstances _____

(Question 15) Denial of examination privileges - Attach documents

State _____ Year _____

Circumstances under which examination privileges denied _____

(Questions 16 and 17) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

(Question 18) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances _____

(Question 19) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

(Questions 20 and 22) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

Status _____

Conviction? _____ Yes _____ No _____ Date _____

Plea? ____ Yes ____ No Date _____

(Question 21) Investigation by any other licensing board - Attach documents

Name of Licensing Board _____ Date _____

Location of Licensing Board _____

Circumstances _____

(Questions 23-24) Medical condition, treatment, use of chemical or illegal substances

Treating organization _____

Address _____ Telephone _____

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

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____ Telephone _____

Contact person at Program _____

(Question 31) Medical Malpractice Claim

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.

Insurer _____

Claimant name _____

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

Please indicate:

1. Patient's condition at point of your involvement;
2. Patient's condition at end of treatment;
3. The nature and extent of your involvement with the patient;
4. Your degree of responsibility for the course of treatment in leading to the claim; and
5. Narrative of event.

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

Your role (circle one):

- | | |
|---------------------------|-------------------------------------|
| 01 Anesthesiologist | 11 PGY 4 |
| 02 Primary Care Physician | 12 PGY 5 |
| 03 Referring Physician | 13 PGY 6 |
| 04 Attending Physician | 14 PGY 7 |
| 05 Consultant Specialist | 15 Workmen's Compensation Evaluator |
| 06 Surgeon | 16 Court Psychiatrist |
| 07 Fellow | 17 On-Call Physician |
| 08 PGY 1 | 18 Group Practitioner/Partner |
| 09 PGY 2 | 19 Other: Specify _____ |
| 10 PGY 3 | 20 Unknown |

Your Legal Representative in this matter (include name, address and telephone number)

Name _____

Firm _____

Address _____

City, State, Zip _____

Phone _____

Indicate Decision, Appeal, Settlement, Dismissal:

If a Court or Arbitration Panel heard your case, indicate the following:

Court _____

Court's location _____

Docket number _____

Date the action was filed _____

Decision determined by (check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date appeal filed (month, day, year) ____/____/____

Date appeal decided: (month, day, year) ____/____/____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of settlement: (month, day, year) ____/____/____

____ Case dismissed against you ____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

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 one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

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

☒ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

or

☐ I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

Title 32 § 3113 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 the Department of Taxes. "Good standing" means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

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).

or

☐ I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment 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.)

or

☐ I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.

or

☐ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security # [REDACTED] Date of Birth [REDACTED]

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

STATEMENT OF APPLICANT

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

Signature of Applicant



Date

10/2/06



042-0010144

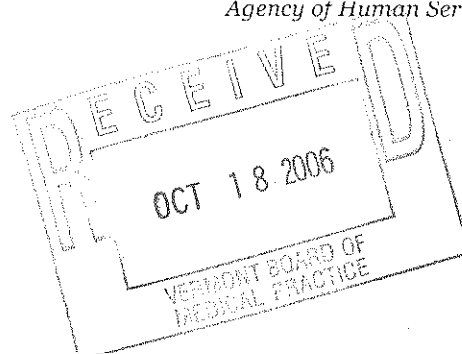
Gailyn B Thomas, MD
Gifford Medical Center OB/GYN
44 Main Street PO Box 2000
Randolph, VT 05060

Department of Health

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

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

Agency of Human Services



Date: October 10, 2006

Dear Physician:

Your 2006 Physician's License Renewal application has been received by this office and cannot be processed until the following information is received.

☐ \$450 renewal fee

Application

Part I

☐ Item 1
☐ Item 2
☐ Item 3
☐ Item 4
☐ Item 5
☐ Item 6
☐ Item 7
☐ Item 8

Part II

☐ Item 9
☐ Item 10
☐ Item 11
☐ Item 12
☐ Item 13
☐ Item 14
☐ Item 15
☐ Item 16

Part III

☐ Item 17
☐ Item 18
☐ Item 19
☐ Item 20
☐ Item 21
☐ Item 22
☐ Item 23
☐ Item 24
☐ Item 25

Part IV

☐ Item 26
☐ Item 27
☐ Item 28
☐ Item 29
☐ Item 30A
☐ Item 30B
☒ Item 31A

Part V

☐ Item 31B
☐ Item 32
☐ Item 33
☐ Item 34
☐ Item 35
☐ Item 36
☐ Item 37A
☐ Item 37B
☐ Item 38
☐ Item 39
☐ Item 40
☐ Item 41
☐ Item 42A
☐ Item 42B
☐ Date
☐ Signature

Child Support, Taxes, Unemployment Compensation Statement

☐ Number 1 – check one of the two statements
☐ Number 2 – check one of the two statements
☐ Number 3 – check one of the three statements

Completed Form A

☐ Completed form

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.

Sincerely,

Medical Practice Board
(802) 657-4220 or (800) 745-7371

Enclosures



December 27, 2005

Done
JJA

To Whom It May Concern:

I am writing to let you know my mailing address will be changing effective 1/13/06

From:

Gailyn B. Thomas, MD
Planned Parenthood of Delaware
625 N. Shipley Street
Wilmington, DE 19801

To:

Gailyn B. Thomas, MD
Department of OB/GYN
Gifford Medical Center
44 South Main Street
P.O. Box 2000
Randolph, VT 05060

JAN 2 2006

My applicable numbers are:
DE state license: C1-0007037
PA state license: MD 048663-L
VT state license: 042-0010144

DEA: BT-3445524
ACOG number: 0386354
ABOG number: 940004

Thank you very much for your time and assistance. Please let me know if there is other information you require.

Sincerely,

G B Thomas M.D.

Gailyn B. Thomas, M.D.

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

10144 pd
\$ 400
G

2004 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

1. Your legal name: THOMAS, GAILYN B

Last Name	First Name	Middle Name	Suffix
-----------	------------	-------------	--------

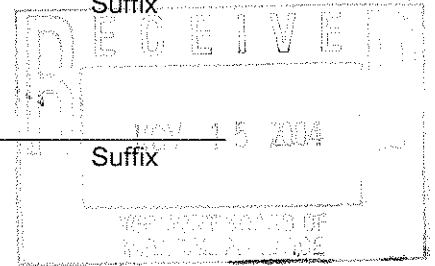
a. Have you ever legally changed your name? ___ Yes X No

If yes, enter your former name and any other name(s) under which you were licensed in Vermont or elsewhere in the past two years;

Last Name	First Name	Middle Name:	Suffix
-----------	------------	--------------	--------

b. Indicate your name, as it should appear on your license:

THOMAS	Gailyn	B.	
Last Name	First Name	Middle Name:	Suffix



2. Your Date of Birth:

Month / Day / Year

3. Home Address:

not listed - as an abortion provider, I
do not list my home address to protect my
children's safety. (Street)

(City)

(State)

(Zip)

4. Work Address:

~~c/o WOMEN'S CHOICE GYNECOLOGY~~
~~23 MANSTFIELD AVENUE~~
~~BURLINGTON, VT 05401~~

Planned Parenthood of Delaware -
625 N. Shipley Street (Street)

(City)

(State)

(Zip)

Wilmington

DE

19801

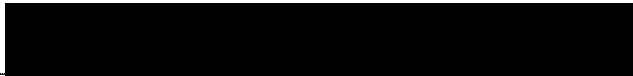
5. Please check your preferred mailing address: ___ Home X Work

NOTE: The mailing address will be publicly listed on the Board's web site.

6. Home Telephone Number with Area Code:

7. Work Telephone Number with Area Code: (302) 655-7296 x 37

8. E-mail address:



Please check here if the Department of Health may use this e-mail address to send you public health information:

☐ yes

☒ no

PART II

9. Were you in active practice in Vermont in the past 12 Months? ☒ yes ☐ no - last practiced 12/03 in VT.

10. Do you hold, or have you ever held, a medical license in any other state? ☒ yes ☐ no

If yes, complete the section below and attach additional pages if necessary.

NH 2000

ME 2001

PA 1992

DE 1995

State	License Number	Type of License	Date Issued	Status (Active or Inactive)
NH	11144	unrestricted	2000	inactive
ME	015540	unrestricted	2001	inactive
PA	MD 048663L	unrestricted	1992	active
DE	C1-0007037	active	1995	active
		unrestricted		

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED ON THE ENCLOSED FORM A.

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

☐ yes ☒ no

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

☐ yes ☒ no

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

☐ yes ☒ no

14. 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

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

☐ yes ☒ no

16. 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

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

☐ yes ☒ no

18. 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

19. 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

20. 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.

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

22. To your knowledge, are you presently the subject of a criminal investigation? [REDACTED]

The following definitions are provided to assist you in answering questions 23 through 25.

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

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

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

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

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

23. 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?

[REDACTED]

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.

24. 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?

[REDACTED]

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.

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

[REDACTED]

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.

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

PART IV

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 physician profile is located at the following website <http://healthyvermonters.com/bmp/mbsearchform.shtml>.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 26 through 31 have changed since your last application. We cannot process your application without them.

26. Criminal Convictions [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 ten years not listed below. **Please provide complete copies of documentation for each matter.**
None reported

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

27. Nolo Contendere/Matters Continued [26 VSA § 1368(a)(2)] ☒ Check here if none

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of

competent jurisdiction not listed below. **Please provide complete copies of documentation for each matter.**

None reported

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

28. **Vermont Board of Medical Practice Matters** [26 VSA § 1368(a)(3)] ☒ Check here if none

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

None reported

(Date)	(Final Disposition - Summary)
--------	-------------------------------

29. **Licensing or Certification Authority Matters in Other States** [26 VSA § 1368(a)(4)]

☒ Check here if none

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, if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

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

30. **Restriction of Hospital Privileges** [26 VSA § 1368(a)(5)]

A. **Revocation/Involuntary Restrictions**

☒ Check here if none

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 if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

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

B. **Other Restrictions**

☒ Check here if none

Please provide a description of all resignations from, or non-renewal 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 if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

(Date)	(Hospital)	(State)
--------	------------	---------

(Nature of Action)

(Action)

In lieu

In settlement

(Reason for Action)

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

A. **Judgments**

☒ 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 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.**

Judgement Arbitration
None reported

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

B. **Settlements**

☒ Check here if none *RWDY & ST*

Please provide a description of all settlements of medical malpractice claims 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.**

9/99 *Delaware County, PA* *\$ 725,000*
(Date) (Court) (State) (Amount of Settlement Against You)

32. **Medical Professional Schools** [26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation if not listed below.

MEDICAL COLL. OF PA., PA

1990

(School/Institution) (City) (State) (Year of Graduation)

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

33. **Graduate Medical Education/Residency** [26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Reading Hospital and Medical Center, PA

Obstetrics and Gynecology

1994

(School/Institution) (Specialty) (City) (State) (Year of
Graduation)

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

34. **Specialty Board Certification** [26 VSA § 1368(a)(9)]

Please verify the following information regarding your specialty board certification and update as necessary using the attached Specialty Codes List.

Obstetrics and Gynecology
American Board of Obstetrics and Gynecology
1996

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
		<input type="checkbox"/> yes <input type="checkbox"/> no			
		<input type="checkbox"/> yes <input type="checkbox"/> no			

35. **Years of Practice** [26 VSA § 1368(a)(10)]

Month and year you started practicing as a physician? 9//1994

36. **Hospital Privileges** [26 VSA § 1368(a)(11)]

☐ Check here if none

List all information for all hospitals where you currently have hospital staff privileges if not listed below:

~~Fletcher Allen (FAHC, MCHV)~~

~~WV~~

~~(2000)~~

ChristianaCare Health System Newark, DE

(Name)

(City)

(State)

(Year Started)

1/2005

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

Note: Answering #37 is optional. By answering, you are granting permission to have this information posted on the web, **exactly as provided to the Board.**

A. **Appointments**

☒ Check here if none

Please provide information about your appointments to medical school or professional school faculties if not listed.

~~University of Vermont~~

~~Burlington, VT~~

~~Clinical Instructor~~

2001 - present

(School)	(City)	(State)	(Nature of Appointment)	From (year)	To (year)
----------	--------	---------	-------------------------	-------------	-----------

B. Teaching

☐ Check here if none

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

University of Vermont

Burlington, VT

Clinical Instructor

2001 - present

Hahnemann University

Philadelphia, PA

Assistant Clinical Professor

1994 - 2000

(School/Institution)	(City)	(State)	(Nature of Teaching)	From (year)	To (year)
----------------------	--------	---------	----------------------	-------------	-----------

38. Publications: [26 VSA § 1368(a)(13)] ☒ Check here if none

Note: Answering #36 is optional. By answering, you are granting permission to have this information posted on the web, exactly as provided to the Board.

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not listed.

None reported

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

39. Activities [26 VSA § 1368(a)(14)] ☐ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web, exactly as provided to the Board.

Please provide information regarding your professional or community service activities and awards if not listed.

May 1990 - The Beatrice Sterling Hollander Memorial Prize
"awarded for promise of leadership, high character and
creativity in her profession"

(Activities or Awards)

40. **Practice Setting** [26 VSA § 1368(a)(15)] ☐ Check here if none

What is the location of your primary practice setting? ~~BURLINGTON, VT~~

Wilmington

Town or City

DE

State

41. **Translating Services** [26 VSA § 1368(a)(16)] ☐ Check here if none

Please identify any translating services available at your primary practice location.

Are any translating services available at your primary practice location? ☐ Not applicable

If yes, please describe here the translating services available:

~~None~~

Spanish

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

42. **Medicaid/New Patients** [26 VSA § 1368(a)(17)]

A. Medicaid participation

Do you participate in the Medicaid program? ☒ yes ☐ no ☐ not applicable

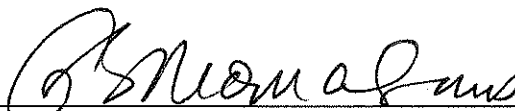
B. New Medicaid Patients

Are you currently accepting new Medicaid patients? ☒ yes ☐ no ☐ not applicable

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: 10.18.04


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
Form A**

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 11 and 12) Withdrawal or denial of License - Attach documents

State _____ Year _____
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated _____

(Question 13) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State _____ Year _____
Circumstances _____

(Question 14) Disciplinary charges or action - Attach documents

Name of organization involved _____ Date _____
Duration _____

Action taken (circle all that apply)

- | | |
|---|---|
| 01 Revocation of right or privilege | 12 Leave of absence |
| 02 Suspension of right or privilege | 13 Withdrawal of an application |
| 03 Censure | 14 Termination or non-renewal of contract |
| 04 Written reprimand or admonition | 15 Medical Records Suspension |
| 05 Restriction of right or privilege | 16 Probation |
| 06 Non-renewal of right or privilege | 17 Assurance of 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) _____ |

Circumstances _____

(Question 15) Denial of examination privileges - Attach documents

State _____ Year _____
Circumstances under which examination privileges denied _____

(Questions 16 and 17) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

(Question 18) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances _____

(Question 19) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

(Questions 20 and 22) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

Status _____

Conviction? _____ Yes _____ No _____ Date _____

Plea? ☐ Yes ☐ No Date _____

(Question 21) Investigation by any other licensing board - Attach documents

Name of Licensing Board _____ Date _____

Location of Licensing Board _____

Circumstances _____

(Questions 23-25) Medical condition, treatment, use of chemical or illegal substances

Treating organization _____

Address _____ Telephone _____

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

Dates of illness or dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____ Telephone _____

Contact person at Program _____

(Question 31) Medical Malpractice Claim

(see attached)

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.

Insurer _____

Claimant name _____

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

Please indicate:

1. Patient's condition at point of your involvement;
 2. Patient's condition at end of treatment;
 3. The nature and extent of your involvement with the patient;
 4. Your degree of responsibility for the course of treatment in leading to the claim; and
 5. Narrative of event.
-
- _____
-
- _____
-
- _____
-
- _____

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

Your role (circle one):

01 Anesthesiologist
02 Primary Care Physician
03 Referring Physician
04 Attending Physician
05 Consultant Specialist
06 Surgeon
07 Fellow
08 PGY 1
09 PGY 2
10 PGY 3

11 PGY 4
12 PGY 5
13 PGY 6
14 PGY 7
15 Workmen's Compensation Evaluator
16 Court Psychiatrist
17 On-Call Physician
18 Group Practitioner/Partner
19 Other: Specify _____
20 Unknown

Your Legal Representative in this matter (include name, address and telephone number)

Name _____

Firm _____

Address _____

City, State, Zip _____

Phone _____

Indicate Decision, Appeal, Settlement, Dismissal:

If a Court or Arbitration Panel heard your case, indicate the following:

Court _____

Court's location _____

Docket number _____

Date the action was filed _____

Decision determined by (check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date appeal filed (month, day, year) ____/____/____

Date appeal decided: (month, day, year) ____/____/____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of settlement: (month, day, year) ____/____/____

____ Case dismissed against you ____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

**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 one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

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

☒ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

or

☐ I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

Title 32 § 3113 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 the Department of Taxes. "Good standing" means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

2. You must check one of the two statements below regarding taxes:

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

or

☐ I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment 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.)

or

☐ I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.

or

☒ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* [REDACTED]

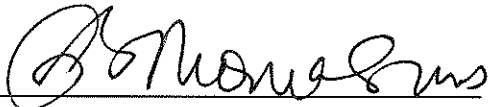
Date of Birth [REDACTED]

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

STATEMENT OF APPLICANT

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

Signature of Applicant



Date

10.18.04

Gailyn B. Thomas, M.D.
Professional Liability Summary

VT license # 042-0010144

1. Bowermaster v. Thomas

Medical malpractice action involving the birth of Brianna Bowermaster on 2/16/95 at Crozer-Chester Medical Center, Upland, Pennsylvania. Plaintiff alleged negligent delivery causing Erb's Palsy. Plaintiff alleged that defendant was negligent for failing to respond properly to a shoulder dystocia encountered during delivery. The case was **settled 9/99 for \$725,000, prior to trial – no admission of liability.**

This case involved a Para 2 white female, prenatal course complicated by gestational diabetes managed by diet and pre-term labor successfully tocolyzed, who underwent a spontaneous vaginal delivery of an 8# 4oz. Female complicated by severe shoulder dystocia following an uneventful labor course. The maneuvers employed in sequence included the McRoberts maneuver, lateral suprapubic pressure, Woods corkscrew maneuver, assessment of the posterior perineum for consideration of deliberate large proctoepisiotomy or mediolateral episiotomy and finally, successful delivery of the posterior shoulder. The infant survived with normal central nervous system function and an Erb's palsy. I was the delivering physician solely responsible for her care.

2. Flick v. Allegheny University et al

Medical malpractice action involving the birth of Victoria Flick on 6/3/97. Plaintiff alleged negligent attempt at a vaginal birth after caesarean section, failure to diagnose uterine rupture and failure to perform a caesarean section in a timely manner. Plaintiff alleged both mother and child suffered multiple injuries including chronic pain in the mother and developmental delay in the infant. The care was provided almost entirely by another member of a group practice to which I belonged. My involvement consisted of one prenatal visit and one postoperative visit. **I was dismissed with prejudice following my deposition. I do not know the final disposition of the case.**

3. Dougherty v. Thomas

Medical malpractice action involving gynecologic surgery undergone by Deborah Dougherty on 9/16/97. Plaintiff underwent a total abdominal hysterectomy for benign disease on 9/16/97. Plaintiff alleges negligent use of a self-retaining retractor resulting in femoral nerve palsy. Plaintiff alleges chronic left lower extremity pain and weakness. I was the attending surgeon for the case. **Unanimous jury verdict for the defendant on 5/3/2002.**

4. Gelle v. Thomas et al

Medical malpractice action alleging failure to diagnose endometrial cancer. Patient was seen by me once in April 1997 and was unable to tolerate recommended evaluation. Failed to return for follow up. Diagnosed spring 2002 with endometrial cancer. Named are all other physicians and gynecologists seen by the patient in the interim. Case pending.

Gailyn B. Thomas, M.D.

VT license # 042-0010144

WRIGHT, YOUNG & McGILVERY, P.C.

ATTORNEYS AT LAW

KEVIN H. WRIGHT
GEORGE L. YOUNG, JR.
MICHAEL E. McGILVERY
DENISE L. JULIANA *
MARK R. ZOLFAGHARI
TERENCE M. PITT
MICHAEL A. MULLEN *
MARY GRADY WALSH *
DIANE L. LYNCH
SYLVAN A. SELYA

* Also Admitted New Jersey Bar

1400 UNION MEETING ROAD
Suite 220 - P.O. Box 3006
Blue Bell, Pennsylvania 19422-3006
(215) 654-1400
FAX (215) 654-0540
E-Mail: wympc@chesco.com

PLEASE RESPOND TO:
BLUE BELL OFFICE

PHILADELPHIA OFFICE:
The Widener Building
The Mezzanine - Suite 240
One South Penn Square
Philadelphia, PA 19107
(215) 567-3400
FAX (215) 567-8536

NEW JERSEY OFFICE:
Washington Professional Campus
900 Route 168 (Black Horse Pike)
Suite B-3
Turnersville, NJ 08012-1453
(856) 227-8602
FAX (856) 227-8507

29 August 2000

Gailyn Thomas, M.D.



RE: Bowermaster v. Thomas, M.D. et al
Our File: 108-134

Dear Dr. Thomas:

As requested, below is a short narrative of your involvement in the above-captioned matter. Please contact us if require additional information.

Bowermaster v. Thomas, is a medical malpractice action involving the birth of the minor Plaintiff, Brianna Bowermaster, on February 16, 1995 at Defendant Crozer-Chester Medical Center, performed by Defendant Gailyn Thomas, M.D. Plaintiff alleges negligent delivery causing Erb's Palsy, a nerve injury to the shoulder. Plaintiff alleges that Defendant Thomas was negligent for failing to properly respond to a shoulder dystocia problem during delivery. This case was settled prior to trial in September, 1999 for \$725,000.

Very truly yours,

WRIGHT, YOUNG & McGILVERY, P.C.

BY:

A handwritten signature in cursive script, reading "Mary Beth Bryan".

Mary Beth Bryan, Paralegal
GEORGE L. YOUNG, JR.

GLY/mbb

WRIGHT, YOUNG & McGILVERY, P.C.
ATTORNEYS AT LAW

KEVIN H. WRIGHT
GEORGE L. YOUNG, JR.
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1400 UNION MEETING ROAD
Suite 220 - P.O. Box 3006
Blue Bell, Pennsylvania 19422-3006
(215) 654-1400
FAX (215) 654-0540
E-Mail: wympe@chesco.com

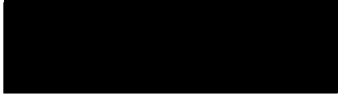
PLEASE RESPOND TO:
BLUE BELL OFFICE

PHILADELPHIA OFFICE:
The Widener Building
The Mezzanine - Suite 240
One South Penn Square
Philadelphia, PA 19107
(215) 567-3400
FAX (215) 567-8536

NEW JERSEY OFFICE:
Washington Professional Campus
900 Route 168 (Black Horse Pike)
Suite B-3
Turnersville, NJ 08012-1453
(856) 227-8602
FAX (856) 227-8507

July 13, 2000

Gailyn Thomas, M.D.



RE: Bowermaster v. Thomas, M.D. et al
Our File: 108-134

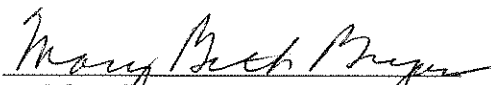
Dear Dr. Thomas:

Pursuant to our telephone conversation, enclosed please find a copy of the Full and Final Release signed by plaintiffs on August 31, 1999, as well as a copy of the March 27, 2000 Order granting Plaintiffs' Petition to Compromise Minor's Claim, in the above-captioned matter.

Kindly advise me if you need any further information

Very truly yours,

WRIGHT, YOUNG & McGILVERY, P.C.

BY: 
Mary Beth Bryan, Paralegal
to George L. Young, Jr.

/mbb
enclosures

108-134

Box 3321

MARKS, FEINER & FRIDKIN, P.C.
BY: MARK S. FRIDKIN, ESQUIRE
IDENTIFICATION NO. 17462
800 STEPHEN GIRARD BUILDING
21 SOUTH 12TH STREET
PHILADELPHIA, PENNSYLVANIA 19107
(215)563-7888

Attorney for Plaintiff(s)

BRIANNA BOWERMASTER, a minor by
her parents and natural guardians, KAREN
BOWERMASTER and
WILLIAM BOWERMASTER, and
KAREN BOWERMASTER and
WILLIAM BOWERMASTER, in their
own right

COURT OF COMMON PLEAS

DELAWARE COUNTY

v.

GAILYN THOMAS, M.D., SUBURBAN
OB-GYN, LTD. And
CROZER CHESTER MEDICAL
CENTER

NO. 96-3940

ORDER

AND NOW, to wit this 27th day of MAR, 2000, upon consideration
of the within Petition To Compromise Minor's Claim, it is hereby ORDERED and
DECREED that:

1. The settlement in compromise of the above case in the gross sum of
\$725,000.00 is approved.

2. The creation of a trust for the benefit of Brianna Bowermaster, in substantially
the same form as attached as Exhibit "A" hereto, of which The Trust Company of Lehigh
Valley will serve as the initial Corporate Trustee and Karen Bowermaster will serve as the
initial Individual Trustee, is approved.

3. That distribution is to be made as follows:

GROSS AMOUNT OF SETTLEMENT:	\$725,000.00
TO: MARKS, FEINER & FRIDKIN, P.C.	\$ 17,827.37
Reimbursement of Costs	
TO: MARKS, FEINER & FRIDKIN, P.C. - FEE	\$176,793.16
25% of Net Settlement	
TO: THE TRUST COMPANY OF LEHIGH VALLEY, CORPORATE TRUSTEE, AND KAREN BOWERMASTER, INDIVIDUAL TRUSTEE, TO BE HELD PURSUANT TO THE TERMS OF THE AFORESAID DECLARATION OF TRUST	\$530,379.47

4. In order to effectuate the Declaration of Trust for the Benefit of Brianna Bowermaster, Karen Bowermaster and Mark S. Fridkin, Esquire are hereby specifically authorized to withdraw any and all monies from the following accounts to be distributed in accordance with this Order:

First Union National Bank	Acct. #1010003244416	\$90,625.00
Sovereign Bank	Acct. #0961042338	\$90,625.00
Patriot Bank	Acct. #5300552741	\$90,625.00
First Trust Bank	Acct. #60061987803	\$90,625.00
National Penn Bank	Acct. #0415685	\$90,625.00
PNC Bank	Acct. #900657164	\$90,625.00
Keystone Savings Bank	Acct. #035500134	\$90,625.00
American Bank	Acct. #100010923	<u>\$90,625.00</u>
Total:		\$725,000.00

BY THE COURT:


J.

FULL AND FINAL RELEASE

1. **FOR AND IN CONSIDERATION** of payment of the statutory primary coverage limit of Gailyn Thomas, M.D. pursuant to the provisions of the Pennsylvania Property and Casualty Insurance Guaranty Act; and for the promise of payment in the amount of \$525,000 made by the Medical Professional Liability Catastrophe Loss Fund, the undersigned do fully release and discharge Gailyn Thomas, M.D., Suburban Associates, the Medical Professional Liability Catastrophe Loss Fund, all other persons, associations and corporations whether or not named herein, their heirs, executors, administrators, successors, assigns and insurers, and their respective agents, servants and employees, from any or all causes of action, claims and demands of whatsoever kind on account of all known and unknown injuries, losses and damages allegedly sustained by the undersigned and, specifically, from any claims or joinders for sole liability, contribution, indemnity or otherwise as a result of, arising from, or in any way connected with all medical professional health care services rendered by the above named Health Care Providers, and on account of which Legal Action was instituted by the undersigned in the Court of Common Pleas of Delaware, Co., PA, Docket No. 96-3940. All sums set forth herein constitute damages on account of physical injuries and sickness, within the meaning of Section 104(a)(2) of the Internal Revenue Code of 1986, as amended. The undersigned does understand, and agrees, that the acceptance of said sum is in full accord and satisfaction of a disputed claim and that the payment of said sum is not an admission of liability by any party named herein.
2. It is understood and agreed that the primary insurer for Gailyn Thomas, M.D. was PIC Insurance Group, Inc., which has been declared insolvent and that the Pennsylvania Property and Casualty Insurance Guaranty Association has become the statutory primary insurer for Gailyn Thomas, M.D.. The amount to be paid by the Pennsylvania Property and Casualty Insurance Guaranty Association is subject to "Non-duplication of Recovery" (40 P.S. §991.1817(a)), which states: "Any person having a claim under an insurance policy shall be required to exhaust first his right under such policy. For purposes of this section, a claim under an insurance policy shall include a claim under any kind of insurance, whether it is a first-party or third party claim, and shall include, without limitation, accident and health insurance, worker's compensation, Blue Cross and Blue Shield and all other coverage's except policies of an insolvent insurer. Any amount payable on a covered claim under this act shall be reduced by the amount of recovery under other insurance." Therefore, the undersigned hereby agrees to accept the statutory primary limit of Gailyn Thomas, M.D., subject to the offset provisions of the Pennsylvania Property and Casualty Insurance Guaranty Association Act. If it should be finally determined by the Court that the offset provision of 40 P.S. §991.1817(a) is

invalid or if no recovery has been received by the undersigned under any other policy of insurance for damages claimed in the legal action noted above, the undersigned reserves the right to seek full recovery of the primary limit of Gailyn Thomas, M.D. exclusively from the Pennsylvania Property and Casualty Insurance Guaranty Association, which is statutorily and exclusively liable for said amount. The undersigned, their heirs, executors, successors and assigns hereby agree to seek or accept no further payment or compensation from the Medical Professional Liability Catastrophe Loss Fund, other than that stated in paragraph 1 of this release.

3. It is expressly understood and agreed that this release and settlement is intended to cover and does cover not only all now known injuries, losses and damages, but any further injuries, losses and damages which arise from, or are related to, the occurrence set forth in the Legal Action noted above.
4. The undersigned hereby agrees, on his/her/their behalf and on behalf of my/our heirs, executors, successors and/or assigns, to satisfy any and all liens that have been asserted and/or which could be or may be asserted for reimbursement of any medical benefits or other benefits provided to the undersigned by a third party as a result of the injuries claimed in the Legal Action referenced herein. Additionally, the undersigned hereby agrees, on his/her/their behalf and on behalf of my/our heirs, executors, successors and/or assigns, to indemnify and save forever harmless the Releasees named in this document from and against any and all claims, demands or actions, known or unknown, made against the Releasees by any person or entity on account of, or in any manner related to or arising from the Legal Action noted above.
5. In the event court approval is required for the settlement, compromise or resolution of this claim, this settlement is conditioned upon plaintiff undertaking any and all necessary action to obtain same.
6. If this settlement is ever determined by any court to be without effect because some necessary court approval was not obtained, or if the released parties are subjected to further legal action or claim which could not have been instituted or presented had proper court approval been obtained by plaintiff, then plaintiff will indemnify the released parties for any future loss, cost, or expense, including but not limited to, reasonable attorney's fees for defending, litigating and settling any such claims or actions, and for any judgment resulting from any such claim or action.
7. It is further understood and agreed that this is the complete release agreement, and that there are no written

or oral understandings or agreements, directly or indirectly, connected with this release and settlement, that are not incorporated herein. This agreement shall be binding upon and inure to the successors, assigns, heirs, executors, administrators, and legal representatives of the respective parties hereto.

8. It is fully understood and agreed that the amount promised to be paid by the Medical Professional Liability Catastrophe Loss Fund shall not become payable until December 31, 1999.
9. It is further understood and agreed and made part hereof, that the undersigned, their family and representatives and their attorney(s) shall not comment, either directly or indirectly, on any aspect of this case or settlement to any member of the news media, or in any way publicize or cause to be publicized in any news or communications media, including but not limited to newspapers, magazines, journals, radio, television, on-line computer systems and law-related publications, the facts of this case, the existence of this settlement and the terms and conditions of this settlement. If the undersigned, their family, representatives and/or attorney(s) file any court document(s) identifying the terms and/or conditions of this settlement, they shall request that the court immediately seal such document(s) and take whatever reasonable steps are necessary to seek to assure that such document(s) are not accessible or disclosed to anyone. This paragraph is intended to become part of the consideration for settlement of this claim.
10. THE UNDERSIGNED HEREBY DECLARES that the terms of this settlement have been completely read; and that they have discussed the terms of this settlement with legal counsel of their choice; and said terms are fully understood and voluntarily accepted for the purpose of making a full and final compromise adjustment and settlement of any and all claims on account of the injuries and damages above-mentioned, and for the express purpose of precluding forever any further or additional suits arising out of the aforesaid claims.

AUG. 31. 1999 3:37PM 12155605169

VO, 2522 P. 5

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 31st day of August 1999.

Karen Bowermaster

(SEAL)

Karen Bowermaster, Individually and Parent and Natural
Guardian of Brianna Bowermaster, a Minor

[REDACTED]
Social Security Number

[Signature]

(SEAL)

William Bowermaster, Individually and Parent and Natural
Guardian of Brianna Bowermaster, a Minor

[REDACTED]
Social Security Number

Matis Fend
Witness



Planned Parenthood®
of Delaware

June 10, 2004

Dear Tracy,

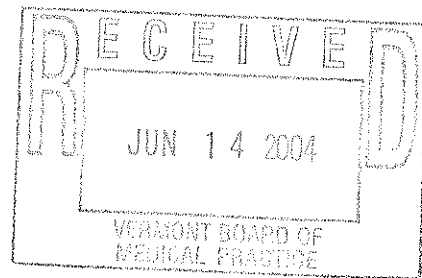
My name is Gailyn B. Thomas. My Vermont medical license number is 042-0010144.
Please update my file to reflect a change of address. My new address is:

Planned Parenthood of Delaware
625 N. Shipley Street
Wilmington, DE 19801.

Thank you very much!

Sincerely,

Gailyn B. Thomas, M.D.
Medical Director
Planned Parenthood of Delaware

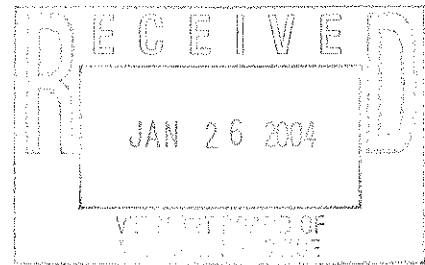


Administrative Office: 625 Shipley Street • Wilmington, Delaware 19801-2249 • 302/655-7296 • FAX 302/655-1907

140 E. Delaware Avenue Newark, DE 19711 302/731-7801
805 S. Governors Avenue Dover, DE 19901 302/678-5200

3009 Philadelphia Pike Claymont, DE 19703 302/798-8000
19 Midway Shopping Center Rehoboth Beach, DE 19971 302/645-2737

[Handwritten signature]



January 21, 2004

To Whom It May Concern:

I am writing to notify you of a recent change in my address. My new office address is;

Gailyn B. Thomas, M.D.
Medical Director
Planned Parenthood of Delaware
625 N. Shipley Street
Wilmington, DE 19801
(302) 655-7296 ext. 37
gthomas@PPDE.org

As a Planned Parenthood Medical Director and abortion provider, I would prefer not to list my home address. Unfortunately, physicians in my position and their families have been the target of harassment and violence in their homes. Thank you for your understanding.

Sincerely,

[Handwritten signature of Gailyn B. Thomas]
Gailyn B. Thomas, M.D.

VT license #

042-6010144

VT DEPT OF
000102 10000000
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2688

malpractice info 00

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE

2002 PHYSICIAN'S LICENSE RENEWAL APPLICATION

I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/02 to 11/30/04.

Instructions

- Please enclose a check in the amount of \$350 payable to the Vermont Department of Health.
Note: Physicians 80 years of age or older or on full-time active military duty (verification required) are exempt from payment of a renewal fee; however, the physician license renewal application must be completed and submitted.
- LATE FEE: Applications post-marked or received after 11/30/02 are assessed a \$25 late fee.
- Please print legibly or type your answers. Please type or print in block letters, one letter (or digit) in each box.
- Answer all questions 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 Parts II and III.
- Please be sure to write your name and license number on each attachment.
- Please be sure to complete the Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions.
- Make a copy of the completed form and all attachments for your own records.
- Do not delegate this important task to an employee. False statements on this form are grounds for unprofessional conduct.
- Please return the document in its entirety at your earliest convenience. Your current license expires on November 30, 2002.

Part I - Identity Questions

Vermont Physician's License Number:

042-0010144

1. Print your full name as you wish it to appear on the license:

First name:

G A I L Y N

Middle name:

B

Last name:

T H O M A S

Extension:

2. Have you ever legally changed your name? ☐ Yes ☒ No

Former name, or any other name under which you were licensed in Vermont or elsewhere in the past two years: _____

3. Your date of birth:

M M D D Y Y Y Y

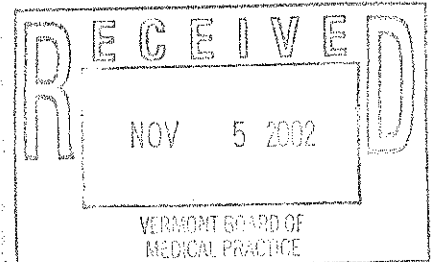
4. Your mailing address: (Check one: ☐ Home address ☒ Work address)

Care of:

W O M E N S C H O I C E G Y N

Street:

23 M A N S F I E L D A V E N U E



14. Have you ever discontinued your education, training, or practice for a period of more than three months, for reasons other than a family situation?
☐ Yes ☒ No
15. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
☐ Yes ☒ No
16. 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
17. 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
18. Are you presently a defendant in a criminal proceeding?
☐ Yes ☒ No

Part III - Confidential Section

Part III is exempt from public disclosure

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

19. To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application?
[REDACTED]
20. To your knowledge, are you presently the subject of criminal investigation?
[REDACTED]

MEDICAL QUESTIONS

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

21. 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?
[REDACTED]

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.

22. 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?
[REDACTED]

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.

23. 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, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-4393 (a confidential line).

DEFINITIONS

In answering the questions above, please use these definitions:

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

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

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

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

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

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. You will receive a copy of your profile prior to its initial release to the public and each time the profile is modified or amended. You will be given a reasonable time to correct factual inaccuracies that appear in such profile. As noted below, certain questions do not need to be answered.

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

24. 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 within the past 10 years. For purposes of this question, "convicted" means that you pleaded guilty or that you were found or adjudged guilty by a court of competent jurisdiction. **Please provide copies of papers fully documenting the convictions.**

Conviction Date								Court	City	State	Crime
M	M	D	D	Y	Y	Y	Y				

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

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

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction. **Please provide copies of papers fully documenting these matters.**

Date								Court	City	State	Charge	Nature of Action
M	M	D	D	Y	Y	Y	Y					
												<input type="checkbox"/> Nolo Contendere
												<input type="checkbox"/> Matter Continued
												<input type="checkbox"/> Nolo Contendere
												<input type="checkbox"/> Matter Continued
												<input type="checkbox"/> Nolo Contendere
												<input type="checkbox"/> Matter Continued

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

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

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed, within the past 10 years. (We will have the documentation on file; we are asking you to provide the description.)

Date								Final Disposition (Summary)
M	M	D	D	Y	Y	Y	Y	

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

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

Please provide a description of all formal charges served by licensing authorities of other states, the findings, conclusions, and orders of such licensing authorities, and final disposition of such matters by the courts, if appealed, in those states within the past 10 years. **Please provide copies of papers fully documenting these matters.**

Date of Final Disposition								Licensing Authority	Court	City	State	Nature of Charges
M	M	D	D	Y	Y	Y	Y					

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

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

A. **Revocation/Involuntary Restrictions**

Please provide a description of any revocation or involuntary restriction of your hospital privileges within the past 10 years that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. **Please provide copies of papers fully documenting these matters.**

Date								Hospital	State	Nature of Restriction	Reason for Restriction
M	M	D	D	Y	Y	Y	Y				

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

B. Other Restrictions

Please provide a description of all resignations from, or nonrenewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital within the past 10 years. **Please provide copies of papers fully documenting these matters.**

Date								Hospital	State	Nature of Action	Action	Reason for Action
M	M	D	D	Y	Y	Y	Y					
											<input type="checkbox"/> In Lieu of	
											<input type="checkbox"/> In Settlement	
											<input type="checkbox"/> In Lieu of	
											<input type="checkbox"/> In Settlement	
											<input type="checkbox"/> In Lieu of	
											<input type="checkbox"/> In Settlement	

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

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

A. Judgments

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past 10 years in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**

Date								Court	State	Nature of Case	Amount Assessed Against You
M	M	D	D	Y	Y	Y	Y				
										<input type="checkbox"/> Judgment	
										<input type="checkbox"/> Arbitration	
										<input type="checkbox"/> Judgment	
										<input type="checkbox"/> Arbitration	
										<input type="checkbox"/> Judgment	
										<input type="checkbox"/> Arbitration	

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

B. Settlements

Please provide a description of all settlements of medical malpractice claims against you within the past 10 years in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**

Date								Court	State	Amount of Settlement Against You
M	M	D	D	Y	Y	Y	Y			
0	8	3	1	1	9	9	9	Delaware County	P A	\$ 725,000.00

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

30. **Medical Professional Schools** [See 26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation. (We will have similar information on file with your original application; we are asking you here to provide an update for the statutory web profile.)

School	City	State	Year of Graduation
The Medical College of Pennsylvania - Philadelphia		P A	1 9 9 0

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

31. **Graduate Medical Education** [See 26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education that you have received. (We will have similar information on file with your original application; we are asking you here to provide an update for the statutory web profile.)

School/Institution	Specialty	City	State	Year of Graduation
The Reading Hospital and Medical Center	OB/GYN residency	Reading	P A	1 9 9 4

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

32. **Specialty Board Certification** [See 26 VSA § 1368(a)(9)]

Enter up to three specialty codes from the enclosed **Specialty Codes List**. List your primary specialty first. If you cannot locate a specialty, please write the specialty name in the space provided.

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
1 1 0 1	OB/GYN	<input checked="" type="checkbox"/> yes <input type="checkbox"/> no	American Board of OB/GYN	1996	due 2006
		<input type="checkbox"/> yes <input type="checkbox"/> no			
		<input type="checkbox"/> yes <input type="checkbox"/> no			

33. **Years of Practice** [See 26 VSA § 1368(a)(10)]

What month and year did you start the practice of medicine (excluding residency/fellowship training)?

M	M	Y	Y	Y	Y
0	9	1	9	9	4

34. **Hospital Privileges** [See 26 VSA § 1368(a)(11)]

List all hospitals where you currently have hospital staff privileges:

Name	City	State	Year Started
Fletcher Allen Health - UVM	Burlington	V T	2000

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

35. **Appointments/Teaching** [See 26 VSA § 1368(a)(12)] Note: Answering #35 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. **Appointments**

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

School	City	State	Nature of Appointment	From (year)	To (year)
UVM School of Medicine	Burlington	V T	Clinical Instructor	2001	present

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

B. **Teaching**

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

School/Institution	City	State	Nature of Teaching	From (year)	To (year)
UVM School of Medicine	Burlington	V T	Clinical Instructor	2001	present
MCP/Hahnemann University	Philadelphia	P A	Assistant Clinical Professor	1994	2000

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

36. **Publications** [See 26 VSA § 1368(a)(13)] Note: Answering #36 is optional. By answering, you are granting permission to have this information posted on the web.

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

Title	Publication	Year

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

37. **Activities** [See 26 VSA § 1368(a)(14)] Note: Answering #37 is optional. By answering, you are granting permission to have this information posted on the web.

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

Activities or Awards

May 1990- The Beatrice Sterling Hollander Memorial Prize
"awarded for promise of leadership, high character
and creativity in her profession"

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

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

What is the location of your primary practice setting?

Town or City:

B	U	R	L	I	N	G	T	O	N						
---	---	---	---	---	---	---	---	---	---	--	--	--	--	--	--

State:

V	T
---	---

39. **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?

☐ Yes ☒ No

If yes, please describe here the translating services available:

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

40. Medicaid/New Patients [See 26 VSA § 1368(a)(17)]

A. Medicaid participation

Do you participate in the Medicaid program?

☒ Yes ☐ No

B. New Medicaid Patients

Are you currently accepting new Medicaid patients?

☒ Yes ☐ No

Part V - Clinical Practice Questions

Please fill in all of the boxes below that describe your practice as a physician (check all that apply):

☒ Active in clinical practice (in direct patient care) in Vermont

☐ Active in clinical practice (in direct patient care) outside Vermont

☐ Administration

☒ Teaching

☒ Research

☐ Not currently in active practice

Are you currently participating in residency or fellowship training? ☐ Yes ☐ No

BEFORE YOU CONTINUE:

■ Are you active in clinical practice (in direct patient care) in Vermont? If the answer is No, please skip the rest of this section and go to Part VI.

■ Are you currently participating in residency or fellowship training? If the answer is Yes, please skip the rest of this section and go to Part VI.

41. What month and year did you start practice of medicine in Vermont (excluding residency/fellowship training)?

M	M	Y	Y	Y	Y
1	1	2	0	0	0

42. For each location in Vermont where you provide patient care, please answer all of the questions:

- If necessary, please describe sites beyond the first 4 on an additional sheet and check this box: ... ☐

A. Town or city (actual location, not mail address):

Site 1:

B	U	R	L	I	N	G	T	O	N						
---	---	---	---	---	---	---	---	---	---	--	--	--	--	--	--

Site 2:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Site 3:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Site 4:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Question	Site 1	Site 2	Site 3	Site 4
B. Number of weeks per year that you spend providing direct patient care at this site: (Full-time is considered to be 48 weeks / year)	<div><div>4</div><div>8</div></div>	<div><div></div><div></div></div>	<div><div></div><div></div></div>	<div><div></div><div></div></div>

Question	Site 1	Site 2	Site 3	Site 4
C. Chose the one description that best fits the practice setting (of each site). (If you provide hospital care to patients who originate from your office or clinic, chose only the setting from which they originate.)				
Community-based practice including associated hospital care (e.g., solo or group office sites, community health center)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital-based practice (e.g., emergency rooms, in-patient services, out-patient services, laboratory, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School or college health center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Business or work site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended care/nursing home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. Specialties at each site:

Please note the specialty, using the code from the enclosed **Specialty Codes List**. For each specialty, enter the average number of hours during which you provide direct patient care, including diagnosis, treatment and clinical reporting, in a working week. Include both the ambulatory care hours and hospital care hours of patients originating from this office or clinic. Exclude on-call hours.

	Site 1	Site 2	Site 3	Site 4
Specialty Code	1 1 0 1			
(Specialty name, if code unknown)				
Hours per week	4 0			
Secondary Specialty, if any				
Hours per week in secondary specialty				
Tertiary Specialty, if any				
Hours per week in tertiary specialty				

E. Please answer each question:

	Site 1	Site 2	Site 3	Site 4
I will accept new patients here	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I participate in Medicaid here	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I will accept new Medicaid patients here	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I participate in Medicare here	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I will accept new Medicare patients here	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I work as a <i>locum tenens</i> here	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part VI - Signature

Reminder - You must also complete the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions

I hereby aver 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: 10.7.02


Applicant's Signature

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 one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

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

✓ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

or

I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

Title 32 § 3113 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 the Department of Taxes. "Good standing" means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

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).

or

I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment 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.)

or

I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.

or

I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #*

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 by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

STATEMENT OF APPLICANT

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

Signature of Applicant



Date 10.7.02

**Residency Training Program(s) not completed - discontinued education, training, practice
(Questions 14 and 15) - Attach documents**

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

**Affecting Health Care Institution Staff Privileges, Employment or Appointment (Question 16) -
Attach documents**

Institution involved _____

Location _____ Year _____

Circumstances _____

Privilege to prescribe controlled substances (Question 17) - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

Criminal Investigation - Proceeding (Questions 18 and 20) - Attach documents

Court _____

City and State _____

Charge _____

Description _____

Status _____

**Vermont Department of Health - Board of Medical Practice
Form A**

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

Withdrawal or denial of License (Questions 9 and 10) - Attach documents

State _____ Year _____
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated _____

**Voluntarily surrendered or resigned a license to practice medicine or any healing art (Question 11)
- Attach documents**

State _____ Year _____
Circumstances _____

Disciplinary charges or action (Question 12) - Attach documents

Name of organization involved _____ Date _____
Duration _____

Action taken (circle all that apply)

- | | |
|---|---|
| 01 Revocation of right or privilege | 12 Leave of absence |
| 02 Suspension of right or privilege | 13 Withdrawal of an application |
| 03 Censure | 14 Termination or non-renewal of contract |
| 04 Written reprimand or admonition | 15 Medical Records Suspension |
| 05 Restriction of right or privilege | 16 Probation |
| 06 Non-renewal of right or privilege | 17 Assurance of 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) _____ |

Circumstances _____

Denial of examination privileges (Question 13) - Attach documents

State _____ Year _____
Circumstances under which examination privileges denied _____

Vermont Department of Health - Board of Medical Practice
Form A

Conviction? ____ Yes ____ No Date _____

Plea? ____ Yes ____ No Date _____

Medical condition, treatment, use of chemical or illegal substances (Questions 21-27)

Treating organization _____

Address _____ Telephone _____

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

Dates of illness of dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____ Telephone _____

Contact person at Program _____

Investigation by any other licensing board (Question 19) - Attach documents

Name of Licensing Board _____ Date _____

Location of Licensing Board _____

Circumstances _____

Vermont Department of Health - Board of Medical Practice

SPECIALTY CODES LIST

(primary care specialties in boldface)

0101	Allergy and Immunology	1501	Anatomic & Clinical Pathology	2201	Surgery
0102	Clinical & Laboratory Immunology	1502	Anatomic Pathology	2202	Surgery Of The Hand
0201	Anesthesiology	1503	Clinical Pathology	2203	Pediatric Surgery
0202	Critical Care Medicine	1504	Blood Banking/Transfusion Medicine	2204	Surgical Critical Care
0203	Pain Management	1505	Chemical Pathology	2205	General Vascular Surgery
0301	Colon & Rectal Surgery	1506	Cytopathology	2301	Thoracic Surgery
0401	Dermatology	1507	Dermatopathology	2401	Urology
0402	Dermatopathology	1508	Forensic Pathology	4001	Abdominal Surgery
0403	Clinical & Laboratory Dermatology	1509	Hematology	4002	Acupuncture
0404	Dermatological Immunology	1510	Immunopathology	4003	Addiction Medicine
0501	Emergency Medicine	1511	Medical Microbiology	4004	Adult Reconstructive Orthopedics
0502	Medical Toxicology	1512	Neuropathology	4005	Allergy
0503	Pediatric Emergency Medicine	1513	Pediatric Pathology	4006	Cardiovascular Surgery
0504	Sports Medicine	1601	Pediatrics	4007	Clinical Pharmacology
0601	Family Practice	1602	Adolescent Medicine	4008	Diabetes
0602	Geriatric Medicine	1603	Clinical & Laboratory Immunology	4009	Facial Plastic Surgery
0603	Sports Medicine	1604	Medical Toxicology	4010	General Practice
0701	Internal Medicine	1605	Neonatal-Perinatal Medicine	4011	Gynecology
0702	Adolescent Medicine	1606	Pediatric Cardiology	4012	Head & Neck Surgery
0703	Cardiac Electrophysiology	1607	Pediatric Critical Care Medicine	4013	Hepatology
0704	Cardiovascular Disease	1608	Pediatric Emergency Medicine	4014	Homeopathic Medicine
0705	Critical Care Medicine	1609	Pediatric Endocrinology	4015	Immunology
0706	Clinical & Lab Immunology	1610	Pediatric Gastroenterology	4016	Legal Medicine
0707	Endocrinology Diabetes & Metabolism	1611	Pediatric Hematology-Oncology	4017	Musculoskeletal Oncology
0708	Gastroenterology	1612	Pediatric Infectious Disease	4018	Neuroradiology
0709	Geriatric Medicine	1613	Pediatric Nephrology	4019	Nutrition
0710	Hematology	1614	Pediatric Pulmonology	4020	Obstetrics
0711	Infectious Disease	1615	Pediatric Rheumatology	4021	Oral & Maxillofacial Surgery
0712	Medical Oncology	1616	Pediatric Sports Medicine	4022	Orthopedic Surgery Of The Spine
0713	Nephrology	1617	Children with Special Health Needs	4023	Orthopedic Trauma
0714	Pulmonary Disease	1701	Physical Medicine & Rehabilitation	4024	Pain Medicine
0715	Rheumatology	1801	Plastic Surgery	4025	Pediatric Allergy
0716	Sports Medicine	1802	Hand Surgery	4026	Pediatric Ophthalmology
0801	Medical Genetics	1901	Preventive Medicine	4027	Pediatric Orthopedics
0802	Clinical Biochemical Genetics	1902	Aerospace Medicine	4028	Pediatric Surgery (Neurology)
0803	Clinical Biochemical/Molecular Genetics	1903	Occupational Medicine	4029	Pediatric Urology
0804	Clinical Cytogenetics	1904	Public Health & General Preventive	4030	Psychoanalysis
0805	Clinical Genetics (Md)	1905	Medical Toxicology	4031	Radioisotopic Pathology
0806	Clinical Molecular Genetics	1906	Underseas Medicine	4032	Sports Medicine (Orthopedic Surgery)
0901	Neurological Surgery		Psychiatry & Neurology	4033	Traumatic Surgery
0902	Critical Care Medicine		(Board Name - Not A Specialty)	4034	Sleep Medicine
1001	Nuclear Medicine	2001	Psychiatry	9001	Rotating Internship (Residency)
1101	Obstetrics & Gynecology	2002	Neurology	9999	Other - Please Specify
1102	Critical Care Medicine	2003	Neurology With Special Qualifications		
1103	Gynecologic Oncology		In Child Neurology		
1104	Maternal & Fetal Medicine	2004	Addiction Psychiatry		
1105	Reproductive Endocrinology	2005	Child & Adolescent Psychiatry		
1201	Ophthalmology	2006	Forensic Psychiatry		
1301	Orthopaedic Surgery	2007	Geriatric Psychiatry		
1302	Hand Surgery	2008	Clinical Neurophysiology		
1401	Otolaryngology	2101	Radiology		
1402	Otology/Neurotology	2102	Diagnostic Radiology		
1403	Pediatric Otolaryngology	2103	Radiation Oncology		
		2104	Radiological Physics		
		2105	Nuclear Radiology		
		2106	Pediatric Radiology		
		2107	Vascular & Interventional Radiology		

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PLEASE RESPOND TO:
BLUE BELL OFFICE

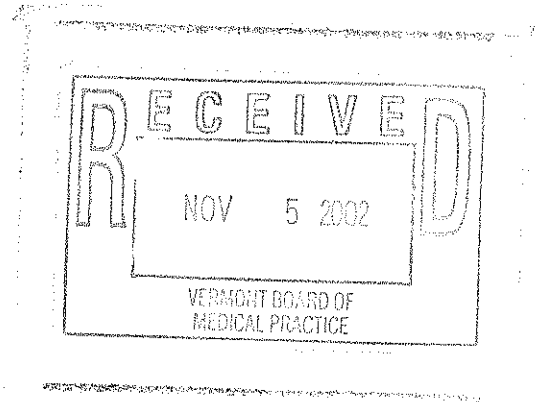
PHILADELPHIA OFFICE:
The Widener Building
The Mezzanine - Suite 240
One South Penn Square
Philadelphia, PA 19107
(215) 567-3400
FAX (215) 567-8536

NEW JERSEY OFFICE:
Washington Professional Campus
900 Route 168 (Black Horse Pike)
Suite B-3
Turnersville, NJ 08012-1453
(856) 227-8602
FAX (856) 227-8507

29 August 2000

Gailyn Thomas, M.D.

RE: Bowermaster v. Thomas, M.D. et al
Our File: 108-134



Dear Dr. Thomas:

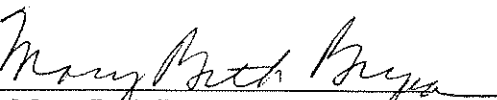
As requested, below is a short narrative of your involvement in the above-captioned matter. Please contact us if require additional information.

Bowermaster v. Thomas. is a medical malpractice action involving the birth of the minor Plaintiff, Brianna Bowermaster, on February 16, 1995 at Defendant Crozer-Chester Medical Center, performed by Defendant Gailyn Thomas, M.D. Plaintiff alleges negligent delivery causing Erb's Palsy, a nerve injury to the shoulder. Plaintiff alleges that Defendant Thomas was negligent for failing to properly respond to a shoulder dystocia problem during delivery. This case was settled prior to trial in September, 1999 for \$725,000.

Very truly yours,

WRIGHT, YOUNG & MCGILVERY, P.C.

BY:


Mary Beth Bryan, Paralegal
GEORGE L. YOUNG, JR.

GLY/mbb

WRIGHT, YOUNG & McGILVERY, P.C.
ATTORNEYS AT LAW

KEVIN H. WRIGHT
GEORGE L. YOUNG, JR.
MICHAEL E. McGILVERY
DENISE L. JULIANA *
MARK R. ZOLFAGHARI
TERENCE M. PITT
MICHAEL A. MULLEN *
MARY GRADY WALSH *
DIANE L. LYNCH
SYLVAN A. SELYA

* Also Admitted New Jersey Bar

1400 UNION MEETING ROAD
Suite 220 - P.O. Box 3006
Blue Bell, Pennsylvania 19422-3006
(215) 654-1400
FAX (215) 654-0540
E-Mail: wympc@chesco.com

PLEASE RESPOND TO:
BLUE BELL OFFICE

PHILADELPHIA OFFICE:
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Turnersville, NJ 08012-1453
(856) 227-8602
FAX (856) 227-8507

July 13, 2000

Gailyn Thomas, M.D.

RE: Bowermaster v. Thomas, M.D. et al
Our File: 108-134

Dear Dr. Thomas:

Pursuant to our telephone conversation, enclosed please find a copy of the Full and Final Release signed by plaintiffs on August 31, 1999, as well as a copy of the March 27, 2000 Order granting Plaintiffs' Petition to Compromise Minor's Claim, in the above-captioned matter.

Kindly advise me if you need any further information

Very truly yours,

WRIGHT, YOUNG & McGILVERY, P.C.

BY: Mary Beth Bryan
Mary Beth Bryan, Paralegal
to George L. Young, Jr.

/mbb
enclosures

MARKS, FEINER & FRIDKIN, P.C.
BY: MARK S. FRIDKIN, ESQUIRE
IDENTIFICATION NO. 17462
800 STEPHEN GIRARD BUILDING
21 SOUTH 12TH STREET
PHILADELPHIA, PENNSYLVANIA 19107
(215)563-7888

108-134
Box 3321

Attorney for Plaintiff (s)

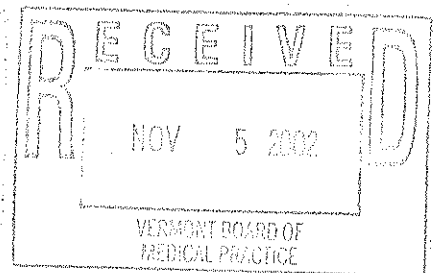
BRIANNA BOWERMASTER, a minor by
her parents and natural guardians, KAREN
BOWERMASTER and
WILLIAM BOWERMASTER, and
KAREN BOWERMASTER and
WILLIAM BOWERMASTER, in their
own right

v.

GAILYN THOMAS, M.D., SUBURBAN
OB-GYN, LTD. And
CROZER CHESTER MEDICAL
CENTER

COURT OF COMMON PLEAS

DELAWARE COUNTY



NO. 96-3940

ORDER

AND NOW, to wit this 27th day of MAR, 2000, upon consideration
of the within Petition To Compromise Minor's Claim, it is hereby ORDERED and
DECREED that:

1. The settlement in compromise of the above case in the gross sum of \$725,000.00 is approved.
2. The creation of a trust for the benefit of Brianna Bowermaster, in substantially the same form as attached as Exhibit "A" hereto, of which The Trust Company of Lehigh Valley will serve as the initial Corporate Trustee and Karen Bowermaster will serve as the initial Individual Trustee, is approved.

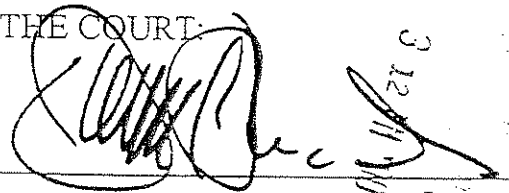
3. That distribution is to be made as follows:

GROSS AMOUNT OF SETTLEMENT:	\$725,000.00
TO: MARKS, FEINER & FRIDKIN, P.C.	\$ 17,827.37
Reimbursement of Costs	
TO: MARKS, FEINER & FRIDKIN, P.C. - FEE	\$176,793.16
25% of Net Settlement	
TO: THE TRUST COMPANY OF LEHIGH VALLEY, CORPORATE TRUSTEE, AND KAREN BOWERMASTER, INDIVIDUAL TRUSTEE, TO BE HELD PURSUANT TO THE TERMS OF THE AFORESAID DECLARATION OF TRUST	\$530,379.47

4. In order to effectuate the Declaration of Trust for the Benefit of Brianna Bowermaster, Karen Bowermaster and Mark S. Fridkin, Esquire are hereby specifically authorized to withdraw any and all monies from the following accounts to be distributed in accordance with this Order:

First Union National Bank	Acct. #1010003244416	\$90,625.00
Sovereign Bank	Acct. #0961042338	\$90,625.00
Patriot Bank	Acct. #5300552741	\$90,625.00
First Trust Bank	Acct. #60061987803	\$90,625.00
National Penn Bank	Acct. #0415685	\$90,625.00
PNC Bank	Acct. #900657164	\$90,625.00
Keystone Savings Bank	Acct. #035500134	\$90,625.00
American Bank	Acct. #100010923	<u>\$90,625.00</u>
Total:		\$725,000.00

BY THE COURT:


J. 12/11/10

FULL AND FINAL RELEASE

1. FOR AND IN CONSIDERATION of payment of the statutory primary coverage limit of Gailyn Thomas, M.D. pursuant to the provisions of the Pennsylvania Property and Casualty Insurance Guaranty Act; and for the promise of payment in the amount of \$525,000 made by the Medical Professional Liability Catastrophe Loss Fund, the undersigned do fully release and discharge Gailyn Thomas, M.D., Suburban Associates, the Medical Professional Liability Catastrophe Loss Fund, all other persons, associations and corporations whether or not named herein, their heirs, executors, administrators, successors, assigns and insurers, and their respective agents, servants and employees, from any or all causes of action, claims and demands of whatsoever kind on account of all known and unknown injuries, losses and damages allegedly sustained by the undersigned and, specifically, from any claims or joinders for sole liability, contribution, indemnity or otherwise as a result of, arising from, or in any way connected with all medical professional health care services rendered by the above named Health Care Providers, and on account of which Legal Action was instituted by the undersigned in the Court of Common Pleas of Delaware, Co., PA, Docket No. 96-3940. All sums set forth herein constitute damages on account of physical injuries and sickness, within the meaning of Section 104(a)(2) of the Internal Revenue Code of 1986, as amended. The undersigned does understand, and agrees, that the acceptance of said sum is in full accord and satisfaction of a disputed claim and that the payment of said sum is not an admission of liability by any party named herein.
2. It is understood and agreed that the primary insurer for Gailyn Thomas, M.D. was FIC Insurance Group, Inc., which has been declared insolvent and that the Pennsylvania Property and Casualty Insurance Guaranty Association has become the statutory primary insurer for Gailyn Thomas, M.D.. The amount to be paid by the Pennsylvania Property and Casualty Insurance Guaranty Association is subject to "Non-duplication of Recovery" (40 P.S. §991.1817(a)), which states: "Any person having a claim under an insurance policy shall be required to exhaust first his right under such policy. For purposes of this section, a claim under an insurance policy shall include a claim under any kind of insurance, whether it is a first-party or third party claim, and shall include, without limitation, accident and health insurance, worker's compensation, Blue Cross and Blue Shield and all other coverage's except policies of an insolvent insurer. Any amount payable on a covered claim under this act shall be reduced by the amount of recovery under other insurance." Therefore, the undersigned hereby agrees to accept the statutory primary limit of Gailyn Thomas, M.D., subject to the offset provisions of the Pennsylvania Property and Casualty Insurance Guaranty Association Act. If it should be finally determined by the Court that the offset provision of 40 P.S. §991.1817(a) is

invalid or if no recovery has been received by the undersigned under any other policy of insurance for damages claimed in the legal action noted above, the undersigned reserves the right to seek full recovery of the primary limit of Gailyn Thomas, M.D. exclusively from the Pennsylvania Property and Casualty Insurance Guaranty Association, which is statutorily and exclusively liable for said amount. The undersigned, their heirs, executors, successors and assigns hereby agree to seek or accept no further payment or compensation from the Medical Professional Liability Catastrophe Loss Fund, other than that stated in paragraph 1 of this release.

3. It is expressly understood and agreed that this release and settlement is intended to cover and does cover not only all now known injuries, losses and damages, but any further injuries, losses and damages which arise from, or are related to, the occurrence set forth in the Legal Action noted above.
4. The undersigned hereby agrees, on his/her/their behalf and on behalf of my/our heirs, executors, successors and/or assigns, to satisfy any and all liens that have been asserted and/or which could be or may be asserted for reimbursement of any medical benefits or other benefits provided to the undersigned by a third party as a result of the injuries claimed in the Legal Action referenced herein. Additionally, the undersigned hereby agrees, on his/her/their behalf and on behalf of my/our heirs, executors, successors and/or assigns, to indemnify and save forever harmless the Releasees named in this document from and against any and all claims, demands or actions, known or unknown, made against the Releasees by any person or entity on account of, or in any manner related to or arising from the Legal Action noted above.
5. In the event court approval is required for the settlement, compromise or resolution of this claim, this settlement is conditioned upon plaintiff undertaking any and all necessary action to obtain same.
6. If this settlement is ever determined by any court to be without effect because some necessary court approval was not obtained, or if the released parties are subjected to further legal action or claim which could not have been instituted or presented had proper court approval been obtained by plaintiff, then plaintiff will indemnify the released parties for any future loss, cost, or expense, including but not limited to, reasonable attorney's fees for defending, litigating and settling any such claims or action, and for any judgment resulting from any such claim or action.
7. It is further understood and agreed that this is the complete release agreement, and that there are no written

or oral understandings or agreements, directly or indirectly, connected with this release and settlement, that are not incorporated herein. This agreement shall be binding upon and inure to the successors, assigns, heirs, executors, administrators, and legal representatives of the respective parties hereto.

8. It is fully understood and agreed that the amount promised to be paid by the Medical Professional Liability Catastrophe Loss Fund shall not become payable until December 31, 1999.
9. It is further understood and agreed and made part hereof, that the undersigned, their family and representatives and their attorney(s) shall not comment, either directly or indirectly, on any aspect of this case or settlement to any member of the news media, or in any way publicize or cause to be publicized in any news or communications media, including but not limited to newspapers, magazines, journals, radio, television, on-line computer systems and law-related publications, the facts of this case, the existence of this settlement and the terms and conditions of this settlement. If the undersigned, their family, representatives and/or attorney(s) file any court document(s) identifying the terms and/or conditions of this settlement, they shall request that the court immediately seal such document(s) and take whatever reasonable steps are necessary to seek to assure that such document(s) are not accessible or disclosed to anyone. This paragraph is intended to become part of the consideration for settlement of this claim.
10. THE UNDERSIGNED HEREBY DECLARES that the terms of this settlement have been completely read; and that they have discussed the terms of this settlement with legal counsel of their choice; and said terms are fully understood and voluntarily accepted for the purpose of making a full and final compromise adjustment and settlement of any and all claims on account of the injuries and damages above-mentioned, and for the express purpose of precluding forever any further or additional suits arising out of the aforesaid claims.

AUG. 31. 1999 3:37PM 12155605369

NO. 2522 P. 5

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 31st day of August 1999.

Karen Bowermaster

(SEAL)

Karen Bowermaster, Individually and Parent and Natural
Guardian of Brianna Bowermaster, a Minor

[REDACTED]
Social Security Number

[Signature]

(SEAL)

William Bowermaster, Individually and Parent and Natural
Guardian of Brianna Bowermaster, a Minor

[REDACTED]

Matis Funder
Witness

MARKS, FEINER, FRIDKIN & BROSS
A PROFESSIONAL CORPORATION
21 SOUTH 12TH STREET, SUITE 800
PHILADELPHIA, PENNSYLVANIA 19107
(215) 563-7888

ASSESSMENT OF DAMAGES HEARING IS REQUIRED
JURY TRIAL DEMANDED

MARKS, FEINER & FRIDKIN, P.C.

BY: MARK S. FRIDKIN

IDENTIFICATION NO. 17462

800 STEPHEN GIRARD BUILDING

21 S. 12th STREET

PHILADELPHIA, PENNSYLVANIA 19107

(215) 563-7888

ATTORNEY FOR Plaintiffs

BRIANNA BOWERMASTER, a minor,
by her parents and natural
guardians, KAREN BOWERMASTER
and WILLIAM BOWERMASTER, and
KAREN BOWERMASTER and WILLIAM
BOWERMASTER in their own right
22 Chester Pike
Ridley Park, PA 19078

VS.

GAILYN THOMAS, M.D.
100 Chester Pike
Ridley Park, PA 19078

and

SUBURBAN ASSOCIATES
100 Chester Pike
Ridley Park, PA 19078

and

CROZER-CHESTER MEDICAL CENTER
15th and Upland Avenues
Upland, PA 19013

Delaware County

COURT OF COMMON PLEAS
CIVIL TRIAL DIVISION

TERM,

No. 96-3940

MAJOR JURY

COMPLAINT IN CIVIL ACTION

(Personal Injury - Medical Malpractice)

NOTICE

You have been sued in court. If you wish to defend against the claims set forth in the following pages, you must take action within twenty (20) days after this complaint and notice are served, by entering a written appearance personally or by attorney and filing in writing with the court your defenses or objections to the claims set forth against you. You are warned that if you fail to do so the case may proceed without you and a judgment may be entered against you by the court without further notice for any money claimed in the complaint or for any other claim or relief requested by the plaintiff. You may lose money or property or other rights important to you.

YOU SHOULD TAKE THIS PAPER TO YOUR LAWYER AT ONCE. IF YOU DO NOT HAVE A LAWYER OR CANNOT AFFORD ONE, GO TO OR TELEPHONE THE OFFICE SET FORTH BELOW TO FIND OUT WHERE YOU CAN GET LEGAL HELP.

PHILADELPHIA BAR ASSOCIATION
LAWYER REFERRAL AND INFORMATION SERVICE

One Reading Center
Philadelphia, Pennsylvania 19107
Telephone: 215-238-1701

AVISO

Le han demandado a usted en la corte. Si usted quiere defenderse de estas demandas expuestas en las páginas siguientes, usted tiene veinte (20) días de plazo al partir de la fecha de la demanda y la notificación. Hace falta asentar una comparecencia escrita o en persona o con un abogado y entregar a la corte en forma escrita sus defensas o sus objeciones a las demandas en contra de su persona. Sea avisado que si usted no se defiende, la corte tomará medidas y puede continuar la demanda en contra suya sin previo aviso o notificación. Además, la corte puede decidir a favor del demandante y requiere que usted cumpla con todas las provisiones de esta demanda. Usted puede perder dinero o sus propiedades u otros derechos importantes para usted.

LLEVE ESTA DEMANDA A UN ABOGADO INMEDIATAMENTE. SI NO TIENE ABOGADO O SI NO TIENE EL DINERO SUFICIENTE DE PAGAR TAL SERVICIO, VAYA EN PERSONA O LLAME POR TELÉFONO A LA OFICINA CUYA DIRECCIÓN SE ENCUENTRA ESCRITA ABAJO PARA AVERIGUAR DONDE SE PUEDE CONSEGUIR ASISTENCIA LEGAL.

ASOCIACIÓN DE LICENCIADOS DE FILADELFA
SERVICIO DE REFERENCIA E INFORMACIÓN LEGAL

One Reading Center
Filadelfia, Pennsylvania 19107
Teléfono: 215-238-1701

FILED
APR 8 2 15 PM '96
OFFICE OF
JUDICIAL SUPPORT
DELAWARE CO. PA.

ASSESSMENT OF DAMAGES HEARING IS REQUIRED
JURY TRIAL DEMANDED

MARKS, FEINER & FRIDKIN, P.C.

BY: MARK S. FRIDKIN

IDENTIFICATION NO. 17462

ATTORNEY FOR Plaintiffs

804 STEPHEN GIRARD BUILDING

21 S. 12th STREET

PHILADELPHIA, PENNSYLVANIA 19107

(215) 563-7888

BRIANNA BOWERMASTER, a minor,
by her parents and natural
guardians, KAREN BOWERMASTER
and WILLIAM BOWERMASTER, and
KAREN BOWERMASTER and WILLIAM
BOWERMASTER in their own right
22 Chester Pike
Ridley Park, PA 19078

vs.

GAILYN THOMAS, M.D.
100 Chester Pike
Ridley Park, PA 19078

and

SUBURBAN ASSOCIATES
100 Chester Pike
Ridley Park, PA 19078

and

CROZER-CHESTER MEDICAL CENTER
15th and Upland Avenues
Upland, PA 19013

Delaware County

COURT OF COMMON PLEAS
CIVIL TRIAL DIVISION

TERM.

No 96-3940

MAJOR JURY

COMPLAINT IN CIVIL ACTION
(Personal Injury - Medical Malpractice)

1. Plaintiff, Brianna Bowermaster, a minor by her parents and natural guardians Karen Bowermaster and William Bowermaster, and Karen Bowermaster and William Bowermaster each in their own right residing at 22 Chester Pike, Ridley Park, PA 19078.

2. Defendant, Gailyn Thomas, M.D., is a medical doctor, licensed to practice medicine in the Commonwealth of Pennsylvania, with offices located at 100 Chester Pike, Ridley Park, PA 19078.

3. Defendant, Suburban Associates, is a medical association, licensed to do business in the Commonwealth of Pennsylvania, with its offices located at 100 Chester Pike, Ridley Park, PA 19078.

4. Defendant, Crozer-Chester Medical Center, is a hospital, open to the public, operated and controlled by the said hospital for treatment of persons injured and sick, for consideration paid to it, located at 15th and Upland Avenues, Upland, PA 19013.

5. At all times material hereto, defendant, Gailyn Thomas, M.D., acted as the agent, servant, and/or employee of defendant, Suburban Associates, or appeared to act as the agent, servant, and/or employee of defendant, Suburban Associates, and was acting within the course and scope of her employment.

6. At all times material hereto, defendant, Gailyn Thomas, M.D., acted as the agent, servant, and/or employee of defendant, Crozer-Chester Medical Center, or appeared to act as the agent, servant, and/or employee of defendant, Crozer-Chester Medical Center, and was acting within the course and scope of her employment.

7. At all times material hereto, defendant, Suburban Associates, acted as the agents, servants, and/or employees of defendant, Crozer-Chester Medical Center, or appeared to act as the agent, servant, and/or workmen of defendant, Crozer-Chester Medical Center, and was acting within the course and scope of their employment.

8. All of the acts alleged to have been done or not to have

been done by the defendants, were done or not done by said defendants, their agents, servants, workmen, and/or employees, acting within the course and scope of their employment with and/or on behalf of said defendants.

9. On or about February 16, 1995, plaintiff, Karen Bowermaster, was a patient of the defendant hospital, Crozer-Chester Medical Center, for the purpose of delivering a baby, minor plaintiff, Brianna Bowermaster, at which time the plaintiffs came under the care of the aforesaid defendant doctor. During delivery of minor plaintiff, Brianna Bowermaster, defendant, Gailyn Thomas, M.D., applied improper techniques causing excessive twisting and force during the course of the delivery. As a result of the negligence, carelessness, and malpractice of the defendants, and each of them, their agents, servants, workmen, and/or employees, the minor plaintiff was caused to suffer severe and permanent injuries as hereinafter more specifically set forth.

10. The negligence, carelessness and malpractice of the defendants, and each of them jointly and/or severally, consisted of the following:

- (a) failing to regard the rights, safety and position of the minor plaintiff;
- (b) failing to observe the standards of skill and care commonly exercised by doctors and hospitals in like circumstances;
- (c) failing to use proper procedures and techniques in the delivery care and treatment of the minor plaintiff;
- (d) failing to properly monitor labor and delivery;
- (e) failing to use the proper techniques during labor and delivery;

(f) using improper twisting and excessive force so as to cause the injuries to minor plaintiff;

(g) causing a humeral fracture to minor plaintiff during delivery;

(h) causing nerve damage to minor plaintiff during delivery;

(i) causing minor plaintiff to suffer Horner's syndrome;

(j) failing to perform an episiotomy and/or a proctoepisiotomy during delivery which was necessary to prevent shoulder dystotia;

(k) failing to make a proper and prompt inquiry into the treatment and care to the minor plaintiff when defendants' carelessness and negligence was or should have been discovered by them;

(l) failing to properly manage plaintiff's shoulder dystocia; and

(m) permitting minor plaintiff to be treated and attended to by incompetent and/or inexperienced medical personnel;

COUNT ONE

BRIANNA BOWERMASTER, a minor, by her parents and natural guardians,
KAREN BOWERMASTER and WILLIAM BOWERMASTER, Plaintiff v. GAILYN
THOMAS and SUBURBAN ASSOCIATES and CROZER CHESTER
HOSPITAL, Defendants

11. Plaintiff, Brianna Bowermaster, a minor by her parents and natural guardians, Karen Bowermaster and William Bowermaster, incorporates by reference all of the averments contained in paragraphs 1 through 10 as fully as though the same were set forth herein at length.

12. As a result of the negligence, carelessness and malpractice of the defendants as aforesaid, the minor plaintiff was

caused to suffer severe and permanent injuries including but not limited to a fractured humerus of the left arm, right shoulder dystocia, brachial plexus injuries, and Horner's syndrome.

13. As a result of the aforesaid, minor plaintiff, Brianna Bowermaster, has undergone great physical pain and mental anguish, and she will continue to endure this pain for an indefinite time in the future to her great detriment and loss, including a loss of life's pleasures.

14. As a result of the negligence, carelessness and malpractice of the defendants as aforesaid, minor plaintiff, Brianna Bowermaster, has, and may, and probably will, be obliged to expend various sums of money for medical care and attention and medicines in and about endeavoring to diagnose, treat, and cure herself of her injuries and disabilities therefrom to her great detriment and loss.

15. As a result of the negligence, carelessness and malpractice of the defendants as aforesaid, minor plaintiff, Brianna Bowermaster, has been unable to attend to her usual daily duties and occupations, and she may and will be unable to attend to same for an indefinite time in the future, to her great detriment and loss.

COUNT TWO

KAREN BOWERMASTER and WILLIAM BOWERMASTER, in their own right, Plaintiffs v. GAILYN THOMAS, M.D. and SUBURBAN ASSOCIATES and CROZER CHESTER HOSPITAL, Defendants

16. Plaintiffs, Karen Bowermaster and William Bowermaster, in their own right, incorporate by reference all of the averments contained in paragraphs 1 through 15 as fully as though the same were set forth herein at length.

17. By reason of the minor plaintiff's injuries, the earnings

of the minor plaintiff will be impaired during the age of her minority, of which earnings, plaintiffs, Karen Bowermaster and William Bowermaster, are legally entitled, all of which has been and probably will continue to be to their financial damage and loss, and they have gone to great expense for her care and cure.

18. As a further result of the recklessness, negligence, and carelessness, of the aforesaid defendants, plaintiffs, Karen Bowermaster and William Bowermaster, observed the trauma inflicted on minor plaintiff, Brianna Bowermaster, during delivery, causing plaintiffs, Karen Bowermaster and William Bowermaster, to suffer severe emotional distress.

WHEREFORE, plaintiffs demand judgment against each of the defendants, jointly and/or severally, in a sum in excess of Fifty Thousand (\$50,000.00) Dollars.

MARKS, FEINER, FRIDKIN & BROSS, P.C.

By: 

MARK S. FRIDKIN

Attorney for Plaintiffs

MSF/mc/MF7289A

Gailyn B. Thomas

Question #37 Addendum

Memberships: American Medical Women's Association
Fellow, American College of Obstetrics
and Gynecology

American Association of Gynecologic
Laparoscopists

Research Participation:

- | | |
|------|--|
| 1999 | Solvay Pharmaceuticals, "A Multicenter, Double-blind Comparison of Estratest hs vs. Estrogen Alone in the Treatment of Menopausal Women Complaining of Loss of Sexual Desire", Principal Investigator |
| 1999 | Solvay Pharmaceuticals, "A Validation Study of the Sexual Interest Questionnaire", Principal Investigator |
| 1999 | National Institutes of Health, "Surveillance Study of Newly Diagnosed Cases Of Endometrial Cancer", Co-investigator |
| 1999 | Medimmune, "A Phase I/II Study to Evaluate the Safety and Immunogenicity of Medi-517, A Virus-like Particle Vaccine Against Human Papillomavirus (HPV) Types 16 and 18 in Healthy Adult Female Volunteers who are HPV-16 or HPV-18 DNA Positive", Principal Investigator |
| 1999 | MedImmune, "A Phase II Double-blind, Randomized, Dose-comparison Study to Evaluate the Safety and Immunogenicity of Medi-517, A Virus-like Particle Vaccine Against Human Papillomavirus Types 16 and 18, in Healthy Adult Female Volunteers", Principal Investigator |
| 2001 | Eli-Lilly, "Prospective Outcomes of Duloxetine in Usual Naturalistic Care in Women With Stress Urinary Incontinence", Principal Investigator |

Renewal - 042.0010144

Name	Gailyn B. Thomas
Credential	042.0010144

Fee Details

Renewal	\$500.00
	\$500.00

Renewal Introduction

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

PHYSICIAN'S LICENSE RENEWAL APPLICATION**PART I**

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

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

INSTRUCTIONS

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

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

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

Be sure to submit:

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

Please Note:

- Your Physician License Renewal Application has been pre-populated with information provided by and previously approved by you prior to the initial release of the Department's physician profiles. Please take this opportunity to correct any factual inaccuracies and/or update any information as appropriate.
- Licensees have a continuing obligation during each two-year renewal period to promptly notify the Board of any change or new information including, but not limited to, disciplinary or other action limiting or conditioning their license or ability to practice in any jurisdiction. Failure to do so may subject the licensee to disciplinary action by the Board.

Thank you.

Renewal Part I**Name:**

Indicate your full legal name (use no initials). If your name has changed at any time during your life and you are not using FCVS, you

must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Last Name:
Thomas

2. First Name:
Gailyn

3. Middle Name:
B.

4. Have you ever legally changed your name?
No

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

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

6. Date of Birth:

[REDACTED]

7. Please provide your preferred email address for receiving important correspondence from this medical board

[REDACTED]

8. Enter your MAILING ADDRESS information:

Attention Vermont Gynecology

Street 1775 Williston Road

City South
Burlington

State VT

Zip 05403

Country United
States

E-mail Address

[REDACTED]

Telephone (802) 735-1252 **Alternate Phone (e.g.
Pager)**

9. Enter your PUBLIC ACCESS address information:

Attention Vermont Gynecology

Street 1775 Williston Road Suite 110

City South Burlington

State VT

Zip 05403

Country United States

Telephone

E-mail Address

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

Renewal Part II

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

Yes

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

Yes

12. If yes, complete the section below.

State	Profession	License Number	Issue Date	Expiration Date	Status
New Hampshire	MD	11144			Inactive

Maine	MD	015540			Inactive
Delaware	MD	C1-0007037			Inactive
Pennsylvania	MD	MD 048663L			Inactive

13. Medical Professional Schools [26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation.

School	Graduation Date
School Name: MEDICAL COLL. OF PA. State: Pennsylvania Country: United States School Type: Medical School Degree: MD	01/01/1990

14. Graduate Medical Education/Residency [26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Site Name	End Date	Specialty
Reading Hospital and Medical Center	01/01/1994	Obstetrics and Gynecology

15. Specialty Board Certification [26 VSA § 1368(a)(9)]

Please verify the following information regarding your specialty board certification and update as necessary.

Specialty	Certification Board	Certification Date	Specialty Expiration Date
Obstetrics and Gynecology	American Board of Obstetrics and Gynecology	01/01/1996	

16. Years of Practice

What year did you start practicing as a medical professional?

1994

17. Hospital Privileges [See 26 VSA § 1368(a)(11)]

List all hospitals where you currently have hospital staff privileges:

Facility Name	State	Start Date	End Date
Gifford Medical Center	Vermont	01/01/2006	
NVRH	Vermont	09/01/2010	
University of Vermont Medical Center	Vermont	08/01/2013	

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

18. Have you ever applied for and been denied a license or certificate to practice medicine or any other healing art in any jurisdiction? If yes, identify the US state or territory, or Canadian territory or province that denied the application and the year in which it was denied, and provide a summary of the circumstances and reason for denial, in the following questions. Upload documents related to the denial where indicated.

No

19. State:

20. Year:

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

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

23. Have you ever withdrawn an application for a license or certificate to practice medicine or any other healing art, in any jurisdiction? If yes, identify the US state or territory, or the Canadian territory or province in which you withdrew the application and the year in which it was withdrawn, and provide a summary of the circumstances and reason for the withdrawal, in the following questions. Upload documents related to the withdrawal where indicated.

No

24. State:

25. Year:

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

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

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

No

29. State:

30. Year:

31. Circumstances:

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

33. Are you currently the subject of any disciplinary charges by, or has disciplinary or employment action ever been taken by, any governmental authority, hospital, health care facility, or professional medical association, other than matters that have already been identified in response to preceding questions. If yes, identify the entity bringing the charges or action, the date, the duration of any discipline or conditions, any action taken, and the circumstances in the following questions. Upload documents related to the charges or actions where indicated.

No

34. Name of entity involved:

35. Date:

36. Duration:

37. Action Taken (add all that apply):

38. Circumstances:

39. Disciplinary charges or actions - Upload documents:

40. Has any US or Canadian state, territorial, or provincial licensing board ever denied you the privilege of taking an examination to be licensed as a health care professional? If yes, identify the state, territory, or province that denied you the privilege and provide the circumstances of the denial in the following questions. Upload documents relating to the denial of the privilege of taking an examination where indicated.

No

41. State:

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

43. Denial of examination privileges - Upload documents:

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

No

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

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

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

No

48. Training program(s):

49. Location of program(s):

50. Year:

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

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

No

53. Entity Investigating:

54. Location of entity investigating:

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

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

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

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

No

59. Entity that took action on prescribing privileges:

60. Action taken:

61. Date of action taken regarding prescribing privileges:

62. Circumstances underlying action on prescribing rights:

63. Action taken on prescribing privileges – upload documents.

64. Are you presently a defendant in a criminal proceeding?

No

65. Court:

66. City and state:

67. Charge:

68. Description:

69. Status:

70. Date:

71. Defendant in criminal proceeding - Upload Documents:

72. Do you currently prescribe, or have you ever prescribed, prescription medication or devices solely in response to communication by computer or other electronic means? This does not include: initial admission orders for newly hospitalized patients; prescribing for patients of a physician for whom you have taken call; prescribing for a patient examined by a licensed advanced practice registered nurse or physician assistant, or other practitioner with whom you have a supervisory or collaborative relationship; continuing medication on a short-term basis for a new patient prior to the new patient's first appointment; or emergency situations in which the life or health of the patient is in imminent danger. Nor would this include the use of an electronic medical record or other system for entering and transmitting prescriptions.

No

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

Renewal Part III

PART III

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

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

74. To your knowledge, are you currently the subject of a criminal investigation that has not yet resulted in charges against you? If yes, provide the jurisdiction, a description of the matter under investigation, and the date you became aware of the investigation in the following questions.

■

75. Jurisdiction:

76. Description of matter under Investigation:

77. Date you became aware of Investigation:

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

79. To your knowledge, are you the subject of an investigation by any other licensing or certification board that has not yet resulted in charges as of the date of this application? If yes, provide the board involved, the date you became aware of the investigation, and a description of the matter under investigation in the following questions and upload relevant documents where indicated.



80. Licensing or certification board conducting investigation:

81. Date of event(s) under investigation:

82. Nature of event(s) under investigation:

83. Pending licensing board investigation – upload documents.

MEDICAL DEFINITIONS

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

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make and exercise reasoned medical judgements, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks and procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

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

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

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

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

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

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



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

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

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



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

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

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



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

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

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

93. Treating organization:

94. Address:

95. Telephone:

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

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

98. Dates of treatment (from, to):

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

100. Address:

101. Telephone:

102. Contact person at Program:

Renewal Part IV

Statutory Profile Questions

In accordance with Vermont law, the Board of Medical Practice collects certain information from licensed or certified health care professionals and maintains it in a data repository that is made available to the public. 26 V.S.A. § 1368. The publicly-available data

base is commonly referred to as the online profile. When licenses are issued to applicants, instructions are provided as to how to review and update the information provided for the online profile. Answering these questions is mandatory, except for certain optional questions. Those that are optional are clearly identified. Information collected for the statutory profiles may be considered by the Board in its review of the license application. Statutory profile information is displayed to the public for only ten years, but the questions are not time-limited and you must respond regarding your full history.

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

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

No

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

Date of Conviction	Court of Conviction	City	State	Description
--------------------	---------------------	------	-------	-------------

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

Have you ever had a criminal involvement that resulted in a case resolved by a plea of "nolo contendere," or where after finding facts that would establish guilt the matter was continued by the court in lieu of a conviction?

No

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

Provide information regarding each criminal involvement resolved by a plea of "nolo contendere," or where after finding facts that would establish guilt the matter was continued by the court in lieu of a conviction.

Date of Charges	Court	City	State	Description of Charges
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107. **Vermont Board of Medical Practice Matters** [See 26 VSA § 1368(a)(3)]

Have you ever been served charges by, or been the subject of an order by the Vermont Board of Medical Practice or other Vermont professional licensing authority? (This includes stipulations, consent orders, or other voluntary resolutions that you accepted after being notified of an investigation, even if no charges were served.)

No

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

Provide information regarding each instance in which you were charged by, or were the subject of an order by the Vermont Board of Medical Practice or other Vermont professional licensing authority, including the findings, conclusions, orders, and final disposition of the matter by the courts, if applicable.

Date	Final Disposition Summary
------	---------------------------

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

Have you ever been charged by, or been the subject of an order by a professional licensing or certification authority in any other US state or territory, or Canadian territory or province? (This includes stipulations, consent orders, or other voluntary resolutions that you accepted after being notified of an investigation, even if no charges were served.)

No

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

Provide information regarding each incident in which you have been charged by or been the subject of an order by a professional licensing or certification authority in any other state, territory, or province. Provide documentation that shows the charges, findings, conclusions, and orders, plus final disposition by any court or appeal authority, if appealed.

Date of Disposition	Licensing Authority	City	State	Description of Disposition
---------------------	---------------------	------	-------	----------------------------

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

111. Have you ever had hospital privileges revoked or involuntarily restricted for reasons related to competence or character?

No

112.

A. Revocation or Restriction of Hospital Privileges Information

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

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

resigned medical staff membership or privileges;

not renewed medical staff membership or privileges; or, -

consented to a restriction of hospital privileges?

No

114. B. Resignation or Nonrenewal of Medical Staff Membership, or Restriction of Privileges Information

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

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

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

- a court judgment against you; or

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

If you have any such cases, you must provide information as requested in the questions below. You must also complete a Medical Malpractice Case Information Form for each. The form is located [here](#) Download the form, fill it out completely, and upload it where indicated. A form must be completed and submitted for each case. You must also provide documentation for each case as explained on the form.

Yes

116. A. Judgments

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

Date of Judgment	Number of Judgments
------------------	---------------------

117. B. Settlements

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

Date Of Settlement
08/31/1999
12/07/2010

118. C. Pending Cases

Provide the information requested in the following table for each case that is currently pending against you.

Date

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

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

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

School	City	State	Nature of Appointment	Year Started	Year Ended
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120. **B. Teaching** Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years.

School/Institution	City	State	Nature of Teaching	Year Started	Year Ended
University of Vermont	Burlington	Vermont	teaching resident physicians in the operating room or hospital	2013	

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

Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

Title	Publication	Publication Date
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122. **Activities** [See 26 VSA § 1368(a)(14)]

Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your professional or community service activities and awards.

Activity or Award

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

Practice Name	City	State	Primary Practice	Languages	Accepts Medicaid?	Accepts New Medicaid Patients?
Vermont Gynecology	South Burlington	Vermont	Yes		Yes	Yes

Statement of Good Standing

124.

State of Vermont Department of Health Board of Medical Practice

Statement of Good Standing

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

I hereby state that either:

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

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

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

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

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

Yes

125. Date:

12/01/2014

Child Support, Taxes

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer these questions.

Regarding Child Support

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

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

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

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due and payable and all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

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

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

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

128. Social Security Number:

██████████

129. Date of Birth:

██████████

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

Yes

131. Date:

12/01/2014

Continuing Medical Education Requirements

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

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

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

b) I was licensed as an MD for the first time in Vermont between December 1, 2012 and November 30, 2013. Accordingly, my

requirement is to have completed at least 15 hours of qualifying AMA PRA Category 1 Credit™ CME and at least one of those hours was on one or more of the following subjects: hospice, palliative care, and/or pain management services. In addition, if I hold or have applied for a DEA number to prescribe controlled substances, at least one of the qualifying hours I completed was on the subject of safe and effective prescribing of controlled substances. I have completed the applicable requirements.

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

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

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

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

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

C

Workforce Survey

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

You must complete the workforce survey before you may complete your application to renew your license. The mandatory workforce survey is accessed by clicking [here](#)

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

Yes

Renewal Payment

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

Credit Card

Review
