Memorandum

To: File

From: Peggy Langlais

Date: 11/2/2006

Re: Licensing Committee Meeting

Flannery, Gary, MD – [redacted]

Hanissian, Paul, MD – Reinstatement

Lacey, Donald, MD - [redacted]

Pope, Sarah, MD - [redacted]

Semogas, Vytas, MD - [redacted]

Simmons, David, MD - [redacted]

Strong, Benjamin, MD [redacted]

VERMONT

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

November 1, 2006

Peter Thomashow, MD
Central Vermont Hospital
Inpatient Psychiatry
PO Box 547
Barre, VT 05641

Dear Dr. Thomashow:

The application for medical licensure for **Paul Hanissian, MD** appears complete, and is enclosed for your review. The applicant will be calling you to schedule a personal interview. Following the interview, you may present the application at the first, regularly scheduled Board meeting.

Should you have any questions or concerns, please let me know. (802) 657-4223.

Sincerely,

Tracy

Tracy Hayes
Administrative Assistant
Board of Medical Practice

Enclosures

042-0010038

control

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
For Office Use Only - Physician Lapsed License Checklist

Reinstatement Lapsed License Physician Status Sheet

Name of Applicant: Reed David Hanissian

Address: DHMC
One Medical Center Drive, Lebanon, NH 03756

Telephone: 603-653-9318

Date Application Received: 10/2/06

1) X Fee of $500

2) X Completed "APPLICATION FOR REINSTATEMENT OF LAPSED LICENSE".
- X Photograph
- X Tax and Child Support Statement [redacted]
- X Form B: Release

[redacted]

3) X Direct verification" "CERTIFICATE OF MEDICAL LICENSURE".
- X NH
- X ME
- ___

4) X Completed Reference Forms mailed directly to the Board by the Chief of Staff of EACH hospital where the applicant has held privileges during the period his/her Vermont license lapsed. Program Director should be substituted for Chief of Staff for applicants who are applying for reinstatement while still in residency training or who have completed a residency within the last year. Note: Check for the number of hospitals and corresponding reference forms.
- X Chief of Staff Richard Reindollar
- X Chief of Staff Kris Strohbahn
- X Chief of Staff Debbie Birenbaum

or ___ Program Director ___

5) X Information on applicant's professional activities in any other jurisdiction during the period the license has lapsed (curriculum vitae (CV)/resume may be attached to fulfill this requirement if the time period is covered or look for the professional activities form to provide a chronology activities).

6) X American Medical Association Profile Form.

7) X National Practitioner Data Bank self query: applicant sends the original, unaltered response to the Board.

8) N/A Completed Form A if applicant answered "Yes" in Section III.

9) ___ Federation Check: Internal Federation Disciplinary Check by computer.

UVMDPJ
Robert Johnson
1991

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, P.O. Box 70
Burlington, VT 05402

APPLICATION FOR REINSTATEMENT OF LAPSED LICENSE PHYSICIAN–MEDICAL DOCTOR

I hereby apply for REINSTATEMENT OF MY LAPSED LICENSURE AS A PHYSICIAN in the state of Vermont.

Part I - Identity Questions

1. Print your full name as you wish it to appear on the license:

Harrison	Paul	David	
Last Name	First Name	Middle Name	Suffix

2. Have you ever legally changed your name? ___**Yes** _X_ **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:

Last Name	First Name	Middle Name	Suffix

3. Your Date of Birth: [redacted]
Month/Day/Year

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OCT - 2 2006
VERMONT BOARD OF MEDICAL PRACTICE

4: Your mailing address: (Check one: □ home address X work address)

Care of: _____

Street: 1 Medical Center Drive

Town/City: Lebanon, NH 03768

State: _____

Zip: _____

5. Your contact information:

Home telephone number with area code: [redacted]

Work telephone number with area code: (603) 653 9312

E-mail Address: [redacted]

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

6. Were you in active practice in Vermont in the past 12 Months? ___ **Yes** X **No**

7. Years of Practice [See 26 VSA § 1368(a)(10)]

Month and year you started practicing as a physician (excluding residency/fellowship training)?

8/1995

8. Have you ever held a Vermont Limited Temporary License: ___ **Yes** X **No**
If yes, License Number _____

9. Do you hold, or have you ever held, a medical license in any other state? X **Yes** ___ **No**

If yes, complete the section below:

State	License Number	Type of License	Date Issued	Status(Active or Inactive)
NH	5485	Full	7/5/1995	Active
ME	014040	Full	8/3/1995	Inactive
VT	042-0010038	Full	6/7/2006	Inactive

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

Part II – Education, Training, Practice and Examinations

10. Premedical Education

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

Name and location of institution	Degree	From	To
Colgate University	AB	1983	1987

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

11. Medical Professional Schools

Please provide the name of the medical professional school you attended and the date 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.)

UMDNJ - Robert Wood Johnson Piscataway, NJ 1991
(School/Institution) (City) (State) (Year of Graduation)

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

12. Graduate Medical Education

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

(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation)
Maine Medical Center	Ob/Gyn	Portland,	ME	1995

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

13. Specialty Board Certification

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	☒ yes □ no	ABOG	1997	Annually
					□ yes □ no			
					□ yes □ no			

14. Examinations

USMLE X FLEX____ National Board____ LMCC____

State Exam____ Which State? _____ If yes, make sure that the scores are included on the Certificate of Medical Licensure to be sent to that Board.

15. International Medical Graduates

A. ECFMG Standard Certificate Number: _____ Date issued: _____

B. Are you a graduate of a fifth pathway program: ____ Yes _____ No

16. Practice

Do you have hospital privileges? X Yes _____ No

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

Name	Address	From/To	Specialty/Subspecialty
Mary Hitchcock Memorial Hospital	1 Medical Center Drive, Lebanon, NH	1995-present	OB/Gyn
Veterans Administration Hospital	White River Junction, VT	1998-present	OB/Gyn
The Cheshire Medical Center	Keene, NH	1995-1998	OB/Gyn

Part III - Licensure and Practice Questions

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

17. Have you ever applied for and been denied a license to practice medicine or any other healing art?
    ___**Yes** _X_**No**
18. Have you ever withdrawn an application for a license to practice medicine or any other healing art?
    ___**Yes** _X_**No**
19. Have you ever voluntarily surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action?
    ___**Yes** _X_**No**
20. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
    ___**Yes** _X_**No**
21. Have you ever been denied the privilege of taking an examination before any state medical examining board?
    ___**Yes** _X_**No**
22. 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** _X_**No**
23. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
    ___**Yes** _X_**No**
24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?
    ___**Yes** _X_**No**
25. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
    ___**Yes** _X_**No**
26. Are you presently a defendant in a criminal proceeding?
    ___**Yes** _X_**No**

Part IV - 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.

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

28. 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 to assist you in answering. Please explain any "**Yes**" answers on Form A.

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.

29. 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.

30. 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.

31. 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.

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 802-223-0400 (a confidential line).

Part V - 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.

32. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] 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. For purposes of this question, "convicted" means that you pleaded guilty or that you were found or adjudged guilty by a court of competent jurisdiction. Please provide copies of papers fully documenting the convictions.

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

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

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

33. **Nolo Contendere/Matters Continued** [See 26 VSA § 1368(a)(2)] 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. Please provide copies of papers fully documenting these matters.

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

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

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

34. **Vermont Board of Medical Practice Matters** [See 26 VSA § 1368(a)(3)] 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. (We will have the documentation on file; we are asking you to provide the description.)

(Date) (Final Disposition – Summary)

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

35. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)] None

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

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

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

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

A. **Revocation/Involuntary Restrictions**

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. Please provide copies of papers fully documenting these matters.

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

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

B. **Other Restrictions** nom

Please provide a description of all resignations from, or nonrenewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. Please provide copies of papers fully documenting these matters.

(Date) (Hospital) (State)

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

□ In Lieu □ In Settlement

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

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

A. **Judgments** nom

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

□ Judgment □ Arbitration

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

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

B. Settlements none

Please provide a description of all pending settlements and settlements of medical malpractice claims against you. Please complete Form A and provide copies of papers fully documenting these matters.

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

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

38. **Appointments/Teaching** [See 26 VSA § 1368(a)(12)] Note: Answering #38 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.

Dartmouth Medical School Hanover, NH Assistant Professor 1995 - present

(School) (City) (State) (Nature of Appointment) From (year) To (year)

(School) (City) (State) (Nature of Appointment) From (year) To (year)

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)

(School/Institution) (City) (State) (Nature of Teaching) From (year) To (year)

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

39. **Publications** [See 26 VSA § 1368(a)(13)] Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web.

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

(Title) (Publication) (Year)

(Title) (Publication) (Year)

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

40. **Activities** [See 26 VSA § 1368(a)(14)] Note: Answering #40 is optional. By answering, you are granting permission to have this information posted on the web.

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

(Activities or Awards)

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

- End of Statutory Profile Questions -

41. **Interview**

A. In which part of Vermont would you prefer to be interviewed? (Northern – Burlington area, Southern – Bennington, Springfield, Central – Montpelier area, or using video technology) Central

B. When are you scheduled to begin work in Vermont? ASAP

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

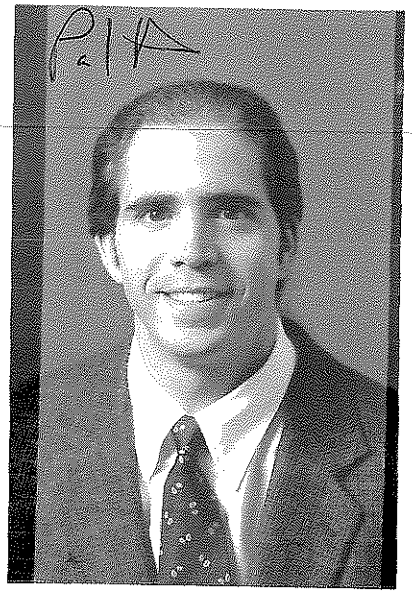
Lyme, NH

Etna, NH

Hanover, NH

Part VI - Photograph

PLEASE PROVIDE A PHOTOGRAPH:
Attach a recent photograph (head and shoulders). Please sign the front of the photograph. Do not use staples



Part VII - Signature

Reminder - You must also complete and sign the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions, Form B, and authorizations for release of information as appropriate, Form C.

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: 8/15/06

Applicant's Signature

Return completed application to:

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, P0 Box 70
Burlington VT 05402-0070

PAUL D. HANISSIAN, M. D.

Address:

Dartmouth-Hitchcock Medical Center
Department of Obstetrics and Gynecology
1 Medical Center Drive
Lebanon, New Hampshire 03756
Phone: 603 650-8563
Fax: 603 650-7795
Email: Paul.D.Hanissian@Hitchcock.ORG

[redacted]

Date and Place of Birth:

[redacted]

Social Security Number:

[redacted]

Citizenship:

United States of America

Education:

Medical School

1991	UMDNJ, Robert Wood Johnson Medical School	M.D.

Undergraduate

1987	Colgate University	A.B. Physics

Work Experience:

Member of the technical staff at NASA-JPL (Jet Propulsion Laboratory)
Summers 1987 – 1989

Postdoctoral Training:

Fellowship

1995 – 1996	Pelvic and Reconstructive Surgery	Dartmouth Hitchcock Medical Center

Internship and Residency

1991 – 1995	Obstetrics and Gynecology	Maine Medical Center

Licensure:

1995 – present	New Hampshire licensed physician and surgeon:	#9485
1995 - 2001	Maine licensed physician and surgeon: (inactive)	#014040

Certification:

1997	Diplomate	The American Board of Obstetrics and Gynecology
1992	Diplomate	National Board of Medical Examiners

Academic Appointments:

1999 – present	Assistant Professor	Department of Obstetrics and Gynecology Dartmouth Medical School
1996 - 1999	Clinical Instructor	Department of Obstetrics and Gynecology Dartmouth Medical School

Hospital Appointments:

1995 – present	Attending Physician	Department of Obstetrics and Gynecology Mary Hitchcock Memorial Hospital
1998 – present	Active Medical Staff	Veterans Administration Hospital
1996 – 1998	Medical staff	Department of Obstetrics and Gynecology The Cheshire Medical Center

Other Professional Positions:

1996 – present	Staff Physician	Planned Parenthood of Northern New England
1999 – present	Staff Physician	The Concord Feminist Health Center

Awards and Honors:

Valedictorian, Memorial High School, Class of 1983, Cedar Grove, NJ
Salutatorian, Colgate University, Class of 1987
Summa Cum Laude
Phi Beta Kappa

1998 APGO Excellence in Teaching Award, Department of Ob/Gyn, Dartmouth Hitchcock Medical Center

Institutional Committee Assignments:

1995 – present	Student Education Committee	Dept. of Ob/Gyn
1996 – present	Resident Selection Committee	Dept. of Ob/Gyn
1999 – present	Surgical Case Review Committee	Dartmouth Hitchcock Medical Center
1996 – 1999	Resident Advisory Group	Dept. of Ob/Gyn
2003 – present	Resident Education Committee	Dept. of Ob/Gyn

2002 – 2003	Birthing Pavilion Flow Committee	Dept. of Ob/Gyn
1999 – 2000	Birthing Pavilion OR Committee	Dept. of Ob/Gyn
1998 – 1999	Obstetrics Education Committee	Dept. of Ob/Gyn

Memberships in Professional Societies:

2001 – present	Member	American Association of Gynecologic Laparoscopists
1999- present	Member	American Urogynecologic Society
1998 – present	Fellow	American College of Obstetrics and Gynecology
1998 – present	Member	Association of Professors of Gynecology and Obstetrics
1997 – present	Member	New Hampshire Medical Society
1994 – 1998	Junior Fellow	American College of Obstetrics and Gynecology

Editorial Service:

2004-present	Reviewer	American Journal of Obstetrics and Gynecology

Teaching Experience:

Medical Student and Undergraduate:

1997 – 2003	Director, Third Year Clerkship, Obstetrics and Gynecology Dartmouth Medical School
2003 – present	Lecturer – Reproductive Systems, Year 2 University of New England Medical School "Abortion"
1999 – present	Lecturer – Scientific Basis of Medicine Course, Year 2 Dartmouth Medical School "Clinical of Gynecologic Problems" "Abortion" "Family Planning"
1995 – present	Instruction during clinical rotation, Dartmouth medical students during third year clinical rotation on Ob/Gyn
1995 – present	Lecturer – Select topics in Gynecologic Oncology for third year medical students. Three hours every 7 weeks
1997 – present	Mentor – Dartmouth medical students providing didactic sessions during third year clerkship as well as professional advising
1998 – present	Preceptor of fourth year Dartmouth medical students for outpatient clinical gynecology electives
1999, 2002	Lecturer, Dartmouth College Philosophy and Logic Class "Abortion"

Resident Teaching

1997 – present	Teaching of residents for inpatient care of obstetrics and gynecology, including operating room supervision
1997 – present	Preceptor of resident continuity clinics for outpatient obstetrics and gynecology

1997 – present	Didactic lectures to residents on leiomyoma, energy systems in operative laparoscopy, abortion, and laparoscopy basics
1997 - 2002	Instructor in yearly animal lab where residents learn operative laparoscopy techniques on pigs

International Professional Activities:

1994 trip to Yerevan, Armenia, to work at Erebuni Hospital on the obstetrics service, as part of a two year ongoing project to improve the state of women's reproductive health in Armenia.

2000 trip to Flores, Guatemala, to work with native Guatemalans with gynecologic surgical problems

Bibliography:

Journal Articles:

Burchard KW. Rowland PA. Berman NB. Hanissian PD. Carney PA. Clerkship enhancement of interpersonal skills. American Journal of Surgery. 189(6):643-6, 2005 Jun.

Posters

Using pre- and post OSCE scores to evaluate changes in student performance by gender in an integrated obstetrics/gynecology/surgery/pediatrics third year clerkship. Association of Professors of Obstetric and Gynecology, March ,2002

Medical Student PowerPoint Presentations in Women's Health: an Eight Year Experience, accepted for poster presentation at APGO/CREOG meeting, 3/06

Whiteside JL, Viazmenski A, Strohbehn K, Hanissian PD. The effect of pelvic organ prolapse on abdominal leak point pressure. Society of Gynecologic Surgeons. March, 2006.

Research

Clinical Co-investigator

A Prospective, Double-Blind, Randomized Study of the Safety and Efficacy of Lower Doses of Premarin and Medroxyprogesterone Acetate in Postmenopausal Women, Co-investigator (1995-1998).

"A Double-Blind, Randomized, Placebo- and Historical-Controlled Study of the Safety and Efficacy of Premarin/Trimegestone for Postmenopausal Hormone Replacement Therapy (PROTOCOL NUMBER: 0915A3-300-US)", Co-investigator (1998-2001).

"The Safety and Efficacy of Lasofoxifene in the Treatment of Vaginal Atrophy in Postmenopausal Women", Co-investigator.

"Evaluation of a Self-Directed HPV Test as a Primary Screen for Cervical Cancer", Co-investigator

"The Development of the Multi-Wavelength Digitized Colposcopy Imaging System", Co-investigator

"Evaluation of Menstrual Cycle Effect on Spectral Data Acquired by the MediSpectra Optical Detection System", Co-investigator

"Multi-Center Pilot Study I of the MediSpectra Optical Detection System for Detection of Cervical Cancer and Its Precursors", Co-investigator

"Use of the MediSpectra Optical Detection System (ODS) as an Adjunct to Colposcopy in the Localization of Squamous Cell Precancerous Lesions", Co-investigator

"Time-Resolved Imaging of Neoplastic Cervical Acetowhitening", Coinvestigator

Invited Presentations

1996 "The Pap Smear", Department of Internal Medicine, Dartmouth Hitchcock Medical Center

1996 "Dysfunctional Uterine Bleeding", Department of Internal Medicine, Dartmouth Hitchcock Medical Center

2002 "Apical Vaginal Support Defects: Understanding Etiology and Surgical Treatment", Department of Obstetrics and Gynecology, Maine Medical Center

2005 "The Pap Smear" Department of Pediatrics, Dartmouth Hitchcock. Medical Center

Professional Development

2001-2002 APGO/Salvoy Scholar: Enrolled in an 18 month course providing theoretic and practical instruction in medical education.

2002 - Berlex Foundation Course on Epidemiology and Biostatics

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 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 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 8/15/06

FORM B

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

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, Paul Hanissian (*Name of Applicant*), HEREBY AUTHORIZE YOU to furnish to the 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: P. I H

Date: 8/23/05

Print or Type Name: Paul Hanissian

Address: 1 Medical Center Drive, Lebanon NH 03756

City, State, Zip Code: _____

Telephone Number: (603) 653 9312

Subscribed and sworn to before me, this 23rd day of August, 2006

Lori Avery Follensbee
Notary Public

LORI AVERY FOLLENSBEE
Notary Public - New Hampshire
My Commission Expires May 3, 2011

Affix Seal

My License Expires: _____

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

State of New Hampshire
Board of Medicine

2 Industrial Park Drive, Suite 8

Concord, NH 03301-8520

(603) 271-6936

Verification Report

This is to certify that the records of the New Hampshire Board indicate the following information:

Licensee: PAUL D HANISSIAN, MD

Specialty: OB OBSTETRICS & GYNECOLOGY

License Number: 9485

Issue Date: 7/5/1995

Expiration Date: 6/30/07

Disciplinary Action: NONE

To expedite the certification of licensure process, the above is the standard format for all professionals regulated by this Board.

Steve Lavin

Credentialing Clerk

SEAL

9-21-06

Date

STATE OF MAINE
BOARD OF LICENSURE IN MEDICINE
137 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0137

JOHN ELIAS BALDACCI
GOVERNOR

EDWARD DAVID, M.D.J.D.
CHAIRMAN

RANDAL C. MANNING
EXECUTIVE DIRECTOR

August 23, 2006

To Whom It May Concern:

This is to certify that the records of the Maine Board of Licensure in Medicine indicate the following with regard to the physician named below:

Physician:	Paul D Hanissian, M.D.
License Number:	014040
Issue Date:	08/03/1995
Expiration Date:	07/10/2001
Current Status:	Withdrawn
Disciplinary Action:	No

Examination Information:

Exam Date	Exam State	Exam Type	Exam Status	Exam Score	Exam Details
		NBME I + NBME II + NBME III	Pass		400019

This license information was last updated on: 08/23/2006

If we can be of further assistance, please do not hesitate to contact the Board office.

Sincerely,

Randal C. Manning
Executive Director

OFFICE LOCATION: 161 CAPITOL STREET, AUGUSTA, ME

PHONE: (207) 287-3601

FAX: (207) 287-6590

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

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):** Richard Reindollar

Address: 1 Medical Center Drive

City, State, Zip Code: Lebanon, NH 03756

Telephone: (603) 65

How long and in what capacity has this individual known you? ~ 1yr, my Chairman

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

Name: Kris Strohbehn

Address: 1 Medical Center Drive

City, State, Zip Code: Lebanon, NH 03756

Telephone: (603) 653 9312

How long and in what capacity has this individual known you? 6 years, my division director

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

Name: Debbie Birenbaum

Address: 1 Medical Center Drive

City, State, Zip Code: Lebanon, NH 03756

Telephone: (603) 653 9312

How long and in what capacity has this individual known you? 11 years, colleague

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.

Chief of Service Form
Return Directly to Board

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

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

Name of Applicant: Paul Hanissian, MD

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

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

Dr. Paul Hanissian was at Dartmouth Hitchcock Medical Center

from 2000 to Present. During that time, he/she was

(List status in the institution): _____

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

Chief of Service Form
Continued

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

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

Name of Applicant: Paul Hanissian MD

How long have you known the applicant and in what capacity? 6 years; colleague & director of his clinical section

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 consults 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 Paul Hanissian for licensure in Vermont.
Name of Physician

Signed: [signature], MD Date: 9/20/06

Print or Type Name and Title: KRIS STROHBEHN, MD

Chief of Service Form
Return Directly to Board

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

RECEIVED
SEP 25 2006

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

Name of Applicant: Paul Hanrisian, MD

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

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

Dr. Paul Hanrisian was at Dartmouth Hitchcock Med Center

from 8-15-95 to present. During that time, he/she was

(List status in the institution): full active staff

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

Chief of Service Form
Continued

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

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

Name of Applicant: Paul Hanissian, MD

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

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 consults 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 Paul Hanissian for licensure in Vermont.
Name of Physician

Signed: _____ Date: 9-21-06

Print or Type Name and Title: Richard Reindollar, MD
Chair, Dept of OB/Gyn
Dartmouth Hitchcock Medical Center
Lebanon, NH

Chief of Service Form
Return Directly to Board

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

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

Name of Applicant: Paul Hanissian, MD

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

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

Dr. Paul Hanissian was at DHMC

from 1995 to present. During that time, he/she was

(List status in the Institution): 1st year - benign pelvic surgery fellow then attending physician since then

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

Chief of Service Form
Continued

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

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

Name of Applicant: P.I Harissian, MD

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

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 consults 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 Paul Harissian for licensure in Vermont.
Name of Physician

Signed: Debra L Brenbaum Date: 9/21/06

Print or Type Name and Title: DEBRA L BRENBAUM

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

State of Vermont
Board of Medical Practice

March 8, 2000

Paul David Hanissian, MD
Dept. Of Obstetrics and Gynecology
Dartmouth-Hitchcock Medical Center
Lebanon, NH 03756

Dear Doctor Hanissian:

Your application for medical licensure appears to be complete. It now becomes your responsibility to contact the Board member listed below to arrange for your personal interview:

Philip P. Trabulsy, M.D.
101 Brae Loch Road
Colchester, Vermont 05446
(802) 893-7624

You must complete your interview within six months from the date of this letter or your application will be considered stale. This means that you will have to update the following: Verifications from states ever licensed; three letters of recommendation and the Federation Disciplinary report.

The full Board will act upon your request for licensure at their first, regularly scheduled Board meeting following your interview. The Board of Medical Practice usually meets on the first Wednesday of each month.

Should you have questions or concerns, please feel free to contact us.

Sincerely,

Kim Johnson
Staff Assistant

/kaj

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

State of Vermont
Board of Medical Practice

March 8, 2000

Philip P. Trabulsy, M.D.
101 Brae Loch Road
Colchester, VT 05446

Dear Doctor Trabulsy:

The application for medical licensure for **Paul David Hanissian, MD** appears complete, and is enclosed for your review. The applicant will be calling you to schedule a personal interview. Following the interview, you may present the application at the first, regularly scheduled Board meeting.

Should you have any questions or concerns, please let me know.

Sincerely,

Kim Johnson
Staff Assistant

/kaj

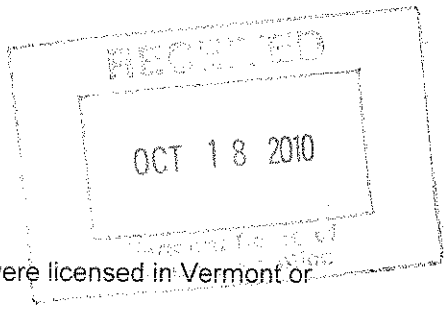
Enclosures

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

2010 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

License Number: 042-0010038



1. **Your legal name:**

   Paul David Hanissian

   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:

   Last Name | First Name | Middle Name: | Suffix

2. **Your Date of Birth:** [redacted]

3. **Mailing Address and email address:**

   DHMC Dept Obstetrics & Gynecology
   One Medical Center Drive
   Lebanon, NH 03756
   [redacted]

4. **Work Address:**

   DHMC Dept Obstetrics & Gynecology
   One Medical Center Drive
   Lebanon, NH 03756
   [redacted]

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:** (603) 653 09 9312

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	1995	active	2009	
ME	1995	inactive		

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.

UMDNJ Robert Wood Johnson, Piscataway
5/22/1991

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.

Maine Medical Center ,ME
1995

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.

Gynecology
American Board of Obstetrics and Gynecology
1997, 2007, 2008, 2009

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
		☐ yes ☐ no			
		☐ yes ☐ no			

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

Month and year you started practicing as a physician? Aug ~~Sep~~ 95

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:

Mary Hitchcock Hospital (NH)
Lebanon, NH

Cheshire Medical Center, Keene, NH

Mount Ascutney Hospital
Windsor, VT

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? [redacted]

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.

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.**

None reported

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.

None reported

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.

None reported

41. Practice Setting [26 VSA § 1368(a)(15)] □ Check here if none

What is the location of your primary practice setting?

~~Lebenon~~, NH
Lebanon

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: 9/24/2010

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
02 Suspension of right or privilege
03 Censure
04 Written reprimand or admonition
05 Restriction of right or privilege
06 Non-renewal of right or privilege
07 Fine
08 Required performance of public service
09 Education/Training/Counseling/Monitoring
10 Denial of rights or privilege
11 Resignation
12 Leave of absence
13 Withdrawal of an application
14 Termination or non-renewal of contract
15 Medical Records Suspension
16 Probation
17 Assurance of Discontinuance
18 Consent Agreement
19 Letter of Agreement
20 Expulsion from Membership
21 Reprimand
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: P.J.A Date: 9/24/2010

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.

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 9/24/2010

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 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

License Number: 042-0010038

1. **Your legal name:**

Paul David Hanissian

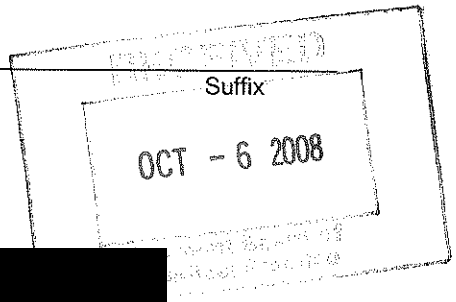
a. Have you ever legally changed your name? ___Yes ↘ No

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:**

Dept. of Obstetrics & Gynecology
Dartmouth Hitchcock Medical Center
Lebanon, NH 03756

[redacted]

4. **Work Address:**

Dept. of Obstetrics & Gynecology, One Medical Center Drive
Dartmouth Hitchcock Medical Center
Lebanon, NH 03756

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:** (603) 653-9312

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	9485	physician/surgeon	1995	active
ME	014040	"	1995	inactive

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.

UMDNJ Robert Wood Johnson, Piscataway
5/22/1991

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.

Maine Medical Center, Portland, ME 1991 - 1995

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

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
4011		☒ yes ☐ no	ABOG	1997	2007
		☐ yes ☐ no			

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

Month and year you started practicing as a physician? August, 1995

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:

Mary Hitchcock Memorial Hospital, Lebanon, NH
Mount Ascutney Hospital, Windsor, VT

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?

[redacted]

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.

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.**

None reported

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.

None reported

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.

None reported

41. **Practice Setting** [26 VSA § 1368(a)(15)] ☐ Check here if none

What is the location of your primary practice setting?

Lebanon, NH

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 Services offered by Dartmouth Hitchcock Medical Center

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: 9/22/08 _____

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
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
02 Suspension of right or privilege
03 Censure
04 Written reprimand or admonition
05 Restriction of right or privilege
06 Non-renewal of right or privilege
07 Fine
08 Required performance of public service
09 Education/Training/Counseling/Monitoring
10 Denial of rights or privilege
11 Resignation
12 Leave of absence
13 Withdrawal of an application
14 Termination or non-renewal of contract
15 Medical Records Suspension
16 Probation
17 Assurance of Discontinuance
18 Consent Agreement
19 Letter of Agreement
20 Expulsion from Membership
21 Reprimand
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 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 [signature] Date 9/22/08

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

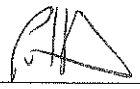
I hereby state that I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

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: 9/22/08 

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.

STATE OF VERMONT -- BOARD OF MEDICAL PRACTICE
2000-2002 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE ONE OF FIVE

I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/00 to 11/30/02.
TWO YEAR RENEWAL FEE: $350.00
Enclose a check in the amount of $350.00 made payable to the Vermont Board of Medical Practice.
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 11/30/00 are assessed a $25.00 late fee.

RECEIVED
VERMONT BOARD OF MEDICAL PRACTICE
1 2000

042-0010038

Paul David Hanissian MD
Dept. of Obstetrics & Gynecology
Dartmouth Hitchcock Medical Center
Lebanon, NH 03756

****

IMPORTANT:

- Please print legibly or type your answers.
- 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 Section II.
- Make a copy of the completed form and all attachments for your own records.
- Do not delegate this important task to an employee, as false statements on this form are grounds for unprofessional conduct.

SECTION I

Name: Hanissian (Last) Paul (First) David (Middle) _____ (Former)

Vermont license number: 042-0010038 Other name(s), if any, under which you were licensed in Vermont and elsewhere since your last renewal _____

"MAILING ADDRESS" will be public and listed on the Board's website. All addresses must be included.

MAILING ADDRESS: Dept/ Ob/ Gyn One Medical Center Drive (Street)

Lebanon (City) NH (State) 03756 (Zip Code) (603) 650-8563 (Telephone)

OFFICE ADDRESS: Same (Street)

_____ (City) _____ (State) _____ (Zip Code) _____ (Telephone)

HOME ADDRESS: [redacted] (Street)

[redacted]

STATE OF VERMONT -- BOARD OF MEDICAL PRACTICE
2000 - 2002 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF FIVE

Are you currently active in clinical practice in Vermont? X Yes ___ No
Did you practice in Vermont during the past 12 months? X Yes ___ No
Do you intend to practice medicine without hospital privileges? ___ Yes X No

SPECIALTY

Specialty: Obstetrics and Gynecology

Subspecialty: _____

American Specialty Board Certified: X Yes _____ No

Specialty: Obstetrics and Gynecology Year Certified: 1997

If applicable, year recertified: _____

PRACTICE

Do you have hospital privileges? X Yes _____ No

List all hospitals where you have, or previously have had, staff privileges. Include full information.

Name	Address	Dates/From-To	Specialty/Subspecialty
Dartmouth-Hitchcock Medical Center	Lebanon, NH	1995-present	Ob/Gyn
Cheshire Medical Center	Keene, NH	1996-1998	Ob/Gyn
VA Hospital	White River Junction, VT	3/98-present	Ob/Gyn

LICENSE IN OTHER JURISDICTIONS

Do you hold, or have you ever held, a medical license in any other state? X Yes ___ No
If yes, complete the section below.

State	License Number	Date Issued	Status (Active, Inactive, Other)
ME	014040	1995	active 2001
NH	9485	7/5/95	active 2001

STATE OF VERMONT -- BOARD OF MEDICAL PRACTICE
2000-2002 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE THREE OF FIVE

SECTION III: "Yes" answers to Questions 1 - 24 require an explanation on the enclosed Form A.
Important note regarding the following questions: "Yes" answers on past renewals must be updated on Form A. For example, if a previously reported malpractice action has been dismissed, indicate that on Form A. **YOU HAVE A CONTINUING OBLIGATION TO UPDATE THE BOARD DURING THE 2000-2002 PERIOD IF THE ANSWER TO ANY OF THE QUESTIONS ON THE NEXT TWO PAGES CHANGE FROM "NO" TO "YES".**

(Section III is for the reporting of information which is retained solely by the Board of Medical Practice and is not part of the data base maintained by the Department of Health.)

DURING THE PAST TWO YEARS:

1. Have you ever applied for and been denied a license to practice medicine or any healing art? ___ Yes _X_ No
2. Have you ever withdrawn an application for a license to practice medicine or any healing art? ___ Yes _X_ No
3. Have you ever voluntarily surrendered or resigned a license to practice medicine or any healing art in lieu of disciplinary action? ___ Yes _X_ 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 _X_ No
5. To your knowledge, are you the subject of an investigation by any **other** licensing board as of the date of this application? [redacted]
6. Have you ever been denied the privilege of taking an examination before any State Medical Examining Board? ___ Yes _X_ No
7. Have you ever discontinued your education, training, or practice for a period of more than three months? ___ Yes _X_ No
8. Have you ever been dismissed, suspended, or asked to leave a residency training program(s) before completion? ___ Yes _X_ 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 _X_ 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 _X_ No
11. Have you ever been notified as a responsible party of a confirmed quality concern (quality of hospital care provided to Medicare patient) by the Peer Review Organization (PRO) in Vermont or elsewhere? ___ Yes _X_ No
12. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim/complaint/demand for damages)? [redacted]
13. Have you ever been turned down for coverage by a malpractice insurance carrier? ___ Yes _X_ No
14. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted by or surrendered to any jurisdiction or federal agency at any time? ___ Yes _X_ No
15. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses? (Note: Driving while intoxicated is ***NOT*** a minor offense.) ___ Yes _X_ No
16. To your knowledge, are you the subject of an investigation for a criminal act? [redacted]

STATE OF VERMONT -- BOARD OF MEDICAL PRACTICE
2000-2002 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FOUR OF FIVE

SECTION III CONTINUED: "Yes" answers to Questions 17 through 24 requires an explanation on the enclosed Form A. For purposes of Questions 17 through 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 addition, 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, well as those used illegally.

"Currently", for purposes of this renewal application, 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 two (2) 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, explain on Form A. [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, explain on Form A. [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, explain on Form A. [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, explain on Form A. [redacted]

21. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If yes, explain on Form A. [redacted]

22. Are you currently engaged in the illegal use of controlled substances? [redacted]

23. If yes to 22, 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, explain on Form A. [redacted]

24. Have you been diagnoses with or have you been treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder? [redacted]

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

SECTION IV

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

PAGE FIVE OF FIVE

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

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

or

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

X 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:**

X 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

X 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 providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant Paul A [redacted] Date 10/23/00

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

State of Vermont
Board of Medical Practice

June 8, 2000

Paul David Hanissian, MD
Dept. Of Obstetrics & Gynecology
Dartmouth-Hitchcock Medical Center
Lebanon, NH 03756

Re: Vermont Medical Licensure
42-0010038

Dear Doctor Hanissian:

Congratulations! On June 7, 2000 by unanimous vote of the Vermont Board of Medical Practice, you were granted a Vermont medical license. Please note your license number indicated above.

Your registration card is enclosed and a wall certificate has been ordered and will be sent to you under separate cover. **All medical licenses must be renewed by November 30, 2000.** You will receive a notification two months prior to renewal.

Please let us know if you have any questions or concerns.

Sincerely,

Kim Johnson
Staff Assistant

PLEASE NOTIFY THIS OFFICE OF ANY ADDRESS CHANGE

Enclosures

Paid 350.00 9/13/99

Paid $50. 10/13/99

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: Paul David Hanissian

Address: Dept. of Obstetrics and Gynecology
Dartmouth-Hitchcock Med. Ctr., Lebanon, NH 03756

Telephone: 603-650-8563

Date Application Received: 8/23/99

X **US Graduate** ____ **Canadian Graduate** ____ **International Graduate**

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

1) X **Fee of $400**

2) X **Completed** "APPLICATION FOR LICENSE TO PRACTICE MEDICINE IN VERMONT"

X **Photograph**

*3) X **Notarized** copy of birth certificate.

Date of Birth: [redacted] Place of Birth: Passaic, NJ

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

(UMDNJ) Robert Wood Johnson Med. Sch. Date: 5/22/91

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

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

- X New Hampshire ____ ____
- X Maine ____ ____
- ____ ____ ____ ____
- ____ ____ ____ ____

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

____ **USMLE** ____ **FLEX**

X **National Boards** ____ **State Examination**

Physician Status Sheet, Page 2 of 2

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

Obstetrics and Gynecology (BC)

____Internal verification of ABMS certificate using toll free number or ABMS Web Site

*9)__X__**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.

X Maine Medical Center DATES 6/92-6/95 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.**

X #1 Chief of Service Barry D. Smith MD

or ~~X Program Director~~ & Donald Kollisch, MD ?

____#2 Active Physician Staff Member Joan Barthold, MD ← She is the one on reference list.

X #3 Active Physician Staff Member John Kettering, MD

11)__X__American Medical Association Profile Form.

*12)__N/A__**ECFMG Certificate** __N/A__**VERIFICATION OF FIFTH PATHWAY**

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

14)__N/A__Completed **Form A** if applicant answered "Yes" in Section III

15)__X__**Applicant's Signature Required:**
__X__Photograph in Section II;
__X__Tax and Child Support Statement - end of Section IV; and
__X__**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 $350. 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: Hanissian (Last) Paul (First) David (Middle) _____ (Former)

Mailing Address: Department of Obstetrics and Gynecology Dartmouth-Hitchcock Medical Center (Street)

Lebanon (City) New Hampshire (State) 03756 (Zip Code) (603) 650-8563 (Phone)

Office Address: same (Street)

_____ (City) _____ (State) _____ (Zip Code) _____ (Phone)

Home Address: [redacted]

City, State, Zip Code: [redacted]

Daytime Telephone Number: Area Code: (603) 650-8563

Date of Birth: Month: [redacted]

Place of Birth: [redacted] Sex: X Male _____ Female

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

SPECIALTY

Specialty: Obstetrics and Gynecology

Subspecialty: _____

American Specialty Board Certified? X Yes ____ No If yes, enclose a **Notarized** copy of Board Certificate.

Specialty?: Obstetrics and Gynecology Year Certified?: 1997

Subspecialty Certificate?: _____ Year Certified? _____

NAME FOR CERTIFICATE - NAME CHANGES - OTHER NAMES LICENSED

Name as it should appear on your license certificate: Paul David Hanissian, M.D.

Have you ever legally changed your name? ____ Yes X 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

(Name and location of Institution)	(From/To)	(Degree)
Colgate University Hamilton, NY 13346		A.B. Physics

MEDICAL EDUCATION-See also Certificate of Medical Education

(Name and location of Institution)	(From/To)	(Degree)
UMDNJ Robert Wood Johnson Medical School Piscataway, NJ 08854		M.D.

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
Maine Medical Center	Scarborough, ME 04074	6/92-6/95	ob/gyn residency

PRACTICE

Do you have hospital privileges? X Yes _____ No

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

Name	Address	From/To	Specialty/Subspecialty
Dartmouth-Hitchcock Medical Center	Lebanon, NH	8/95-present	Ob/Gyn
Cheshire Medical Center	Keene, NH 03431	6/96-6/98	Ob/Gyn
VA Hospital	White River Junction, VT 05009	3/98-present	Ob/Gyn

OTHER LICENSES

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

Do you hold, or have you ever held, a medical license in any other state? X 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)
New Hampshire	9485	7/5/95	active
Maine	014040		active

EXAMINATIONS

USMLE OR FLEX EXAMINATION:
Have you ever taken the USMLE or FLEX examination? ____ Yes X 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? X 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 X 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): Burlington, VT

When are you scheduled to begin work in Vermont? none-Good Neighbor Clinic

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

Hanover, New Hampshire 95-present

Portland, Maine 1991-1995

New Brunswick, New Jersey 1989-1991

INTERNATIONAL MEDICAL GRADUATES

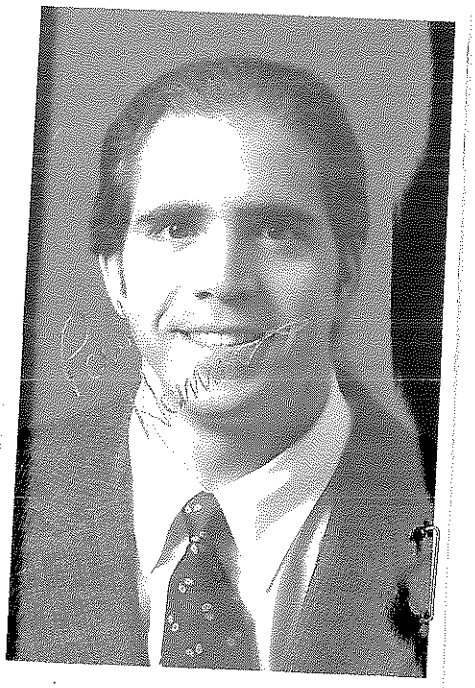
ECFMG Standard Certificate Number: _____ Date Issued: _____

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.**



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 __X__ No

2. Have you ever withdrawn an application for a license to practice medicine or any healing art? ____ Yes __X__ No

3. Have you ever voluntarily surrendered or resigned a license to practice medicine or any healing art in lieu of disciplinary action?
____Yes __X__ 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 __X__ No

5. To your knowledge, are you the subject of an investigation by any **other** licensing board as of the date of this application? [redacted]

6. Have you ever been denied the privilege of taking an examination before any State Medical Examining Board?
____Yes __X__ No

7. Have you ever discontinued your education, training, or practice for a period of more than three months?
____Yes __X__ No

8. Have you ever been dismissed or asked to leave a residency training program(s) before completion?____ Yes __X__ 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 __X__ 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 __X__ 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 __X__ 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)? [redacted]

13. Have you ever been turned down for coverage by a malpractice insurance carrier? ____Yes __X__ 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__X__ 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__X__ No

16. To your knowledge, are you the subject of an investigation for a criminal act? [redacted]

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]

University of Medicine and Dentistry of New Jersey

Robert Wood Johnson Medical School

Be it known that upon the recommendation of the Faculty and by the authority of the Board of Trustees, the University of Medicine and Dentistry of New Jersey hereby confers upon

Paul David Hanissian

the degree of

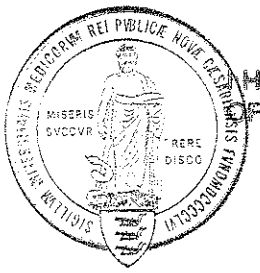
Doctor of Medicine

with all the rights and privileges thereto.

In witness whereof we have hereunto affixed our signatures and the seal of the University in the State of New Jersey this twenty-second day of May, 1991.

Stanley S. Bergen Jr.
President of the University

Herman A. Tillman
Dean



I HEREBY ATTEST THIS TO BE A TRUE COPY OF THE ORIGINAL DOCUMENT

Notary Public 8/20/99

Robert A. Rosenwald
Chairman, Board of Trustees

Francis X. Kelley
Secretary, Board of Trustees

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

JUL 1999
Vermont Board of Medical Practice

CERTIFICATE OF MEDICAL EDUCATION

To be completed by an officer of your School of Medicine

I hereby certify that Paul D. Hanissian, M.D. (Name) was admitted to the

UMDNJ, Robert Wood Johnson School of Medicine

in Piscataway, NJ (City and State) on Aug. 24, 1987 (Date)

and completed all requirements for graduation on May 17, 1991 (Date).

A M.D. (Specify certificate/diploma/degree) was granted on May 22, 1991 (Date).

(AFFIX SEAL)

Date: July 22, 1999

Signed: John Rogalski
(Authorized Officer of the School)
John Rogalski, Assistant Registrar

STATE OF MAINE
BOARD OF LICENSURE IN MEDICINE
137 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0137

ANGUS S. KING, JR.
GOVERNOR

EDWARD DAVID, M.D.J.D.
CHAIRMAN

RANDAL C. MANNING
EXECUTIVE DIRECTOR

August 12, 1999

To Whom It May Concern:

This is to certify that the records of the Maine Board of Licensure in Medicine indicate the following with regard to the physician named below:

Physician:	Paul D. Hanissian, M.D.
License Number:	014040
Issue Date:	8/3/95
Expiration Date:	3/31/01
Current Status:	Active
License Method:	NBME I + NBME II + NBME III
Disciplinary Action:	None

If we can be of further assistance, please do not hesitate to contact the Board office.

Sincerely yours,

Maureen S. Lathrop
Administrative Secretary

AUG 1999
Vermont Board
Of
Medical Practice

BOARD SEAL

OFFICE LOCATION: TWO BANGOR STREET, AUGUSTA, ME
PHONE: (207) 287-3601
FAX: (207) 287-6590

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

CERTIFICATE OF MEDICAL LICENSURE

This section must be completed by the regulatory authority in the states in which **you now hold or have ever held** a license to practice medicine.

I, LESLIE SHERMAN Secretary of the

NEW HAMPSHIRE State Board of Medical Examiners, certify that

Paul D. Hanissian, M.D.

was granted Certificate Number 9485 to practice medicine in the

State of New Hampshire on the

5 day of July, 19 95,

based on CREDENTIALS and that said certificate has never been revoked,

suspended or conditioned in any way, or the licensee has never been disciplined by the Board in any way.

NOTE: If licensed by written examination the secretary should further certify:

I further certify that the aforesaid N/A in his/her written

examination before this Board, obtained a general average of _____ percent in the

following branches:

(The subjects of the examination and rating of each must be stated in full.)

(AFFIX SEAL)

Diana DeBois
(Secretary/~~Director~~)

8-12-99
(Date)

NATIONAL BOARD OF MEDICAL EXAMINERS®

Record of Scores and 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: VT Board of Med Practice
Licensing & Registration
Redstone Building
26 Terrace Street
Montpelier, VT 05609-1106

Date: 08/05/1999

Examinee: Paul David Hanissian

Examinee ID: 3-400-019-0
Date of Birth: [redacted]

NBME Certification Date: 07/01/1992

Certificate#: 400019

This record shows only NBME passing scores for each NBME examination reported on this document unless a complete NBME examination history has been requested by the examinee. If applicable, also results for USMLE Steps taken by this examinee (and for which scores have been reported to date) are shown.

This examinee has successfully completed the examination, education and training requirements for NBME certification.

NBME PART I

			Total		Individual Subject Scores						
Test Date	Pass/Fail	Score Scale	Score	(Min.Pass)	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
06/1989	**Pass**	**Three-Digit**	490	(380)	560	515	525	425	490	460	465
		Two-Digit	81	(75)	85	82	83	77	81	79	79

NBME PART II

			Total		Individual Subject Scores					
Test Date	Pass/Fail	Score Scale	Score	(Min.Pass)	Med	Surg	ObGyn	PM/PH	Peds	Psych
09/1990	**Pass**	**Three-Digit**	450	(290)	530	395	480	480	360	510
		Two-Digit	80	(75)	83	77	81	81	76	82

NBME PART III

			Total	
Test Date	Pass/Fail	Score Scale	Score	(Min.Pass)
03/1992	**Pass**	**Three-Digit**	505	(315)
		Two-Digit	82	(75)

* * * END OF DOCUMENT * * *

See reverse side for explanation of information reported above.

VT 1250

Authenticity of NBME Record of Scores

Original, certified copies of the NBME Record of Scores are printed on green safety paper and are produced only by the NBME. The embossed NBME seal in the lower left corner certifies the authenticity of this document. Alteration or forgery of the NBME Record of Scores may result in appropriate legal action or other action consistent with NBME or USMLE policies.

INTERPRETATION OF SCORES

NBME Part I and Part II Examinations Prior to June 1991

The most recent total test and subject scores are reported. The total test score is based on the total number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are on a scale with a mean of 500 and a standard deviation of 100, in increments of 5. Most scores fall between 250 and 750.

NBME Part I and Part II Examinations June 1991 and Thereafter

The most recent total test score is reported. This score is on a scale with a mean of 200 and a standard deviation of 20, in increments of 1. Most scores fall between 150 and 250.

All NBME Part III Examinations

The most recent total test score is reported. This score is on a scale with a mean of 500 and a standard deviation of 100, in increments of 5. Most scores fall between 250 and 750.

Two-Digit NBME Scores

For all NBME scores, an equivalent value scale score on a two-digit scale is also provided. The scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

USMLE Step 1, Step 2 and Step 3

Reports of scores on USMLE include a complete score history, and notations of any examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For recent administrations, the mean and standard deviation of scores on the three-digit scale for first-time examinees from medical schools in the United States are approximately 205 and 20, respectively, and most scores fall between 145 and 260. An equivalent value score on a two-digit scale is also provided. A score of 82 on the two-digit scale is equivalent to a score of 200 on the three-digit scale. A score of 75 on the two-digit scale is always the minimum passing score. The recommended minimum passing score on each scale is shown on the front of the transcript next to the examinee's score for each examination administration. The level of proficiency required to meet the recommended minimum passing level for each Step of USMLE is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 6 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Special circumstances in connection with the administration of USMLE may result in one of the following annotations being listed next to the score for that examination:

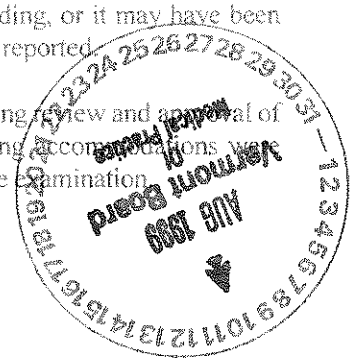
Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, inconsistency of performance within the examination or between administrations within the same Step. **No score is reported.**

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

Irregular Behavior - The USMLE Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. To obtain information regarding the nature of the irregular behavior, the full record of the deliberations and determination of the Committee on Irregular Behavior can be requested by contacting the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9600.

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

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



AMERICAN BOARD of MEDICAL SPECIALTIES®
PUBLIC EDUCATION PROGRAM

Verification of Certification Results

1 doctors found

Results found for first name: **Paul** and last name: **Hanissian**

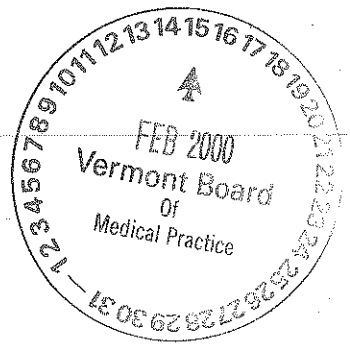
	Name	City	State
1	**PAUL DAVID HANISSIAN MD**	**HANOVER**	**NH**
	Certificates include OBSTETRICS & GYNECOLOGY		

Refer All Questions Regarding The ABMS Public Education Program To: 47 Perimeter Center East, Suite 500 Atlanta, GA 30346 (800) 733-2267 or use our feedback form.

Home | What is Board Certified? | Certified Doctor Locator | Verification of Board Certification | ABMS The Organization

This site was developed and is maintained by TMP Worldwide, a licensee of the American Board of Medical Specialties.

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: Maine Medical Center

Address: 22 Bramhall Street
Portland, ME 04102

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

I hereby certify that Paul D. Manissian, M.D. was enrolled in the
Name

Program Type (residency, fellowship)

Obstetrics and Gynecology

Department (e.g. Radiology, Internal Medicine)

at this institution from 07 / 01 / 91 to
Month Day Year

06 / 30 / 99
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

06 / [illegible] / 99
Month Day Year

(AFFIX SEAL)

Date: 2/9/00

Signed: HMT
(Official of the Sponsoring Institution)

Print Name: Hector M Tarraza M.D.

Title: Chairman

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, Paul David Hanissian, M.D., 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: Paul Hanissian

Date: 8/20/99

Print or Type Name: Paul David Hanissian, M.D.

Address: Department of Obstetrics and Gynecology Dartmouth Hitchcock Medical Center

City, State, Zip Code: Lebanon, New Hampshire 03756

Telephone Number: (603) 650-8563

Subscribed and sworn to before me, this 20th day of August, 1999.

Sylvia M. Pinard
Notary Public

Affix Seal

My License Expires: SYLVIA M. PINARD, Notary Public My Commission Expires October 9, 2001

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

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): Barry D. Smith, M.D.

Address: Dept. Ob/Gyn Dartmouth-Hitchcock Medical Center

One Medical Center Drive

City, State, Zip Code: Lebanon, NH 03756

Telephone: (603) 650-7795

How long and in what capacity has this individual known you? Department Chairman 1995

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

Name: Joan Barthold, M.D.

Address: Dept. Ob/Gyn Dartmouth-Hitchcock Medical Center

One Medical Center Drive

City, State, Zip Code: Lebanon, NH 03756

Telephone: (603) 650-7795

How long and in what capacity has this individual known you? colleague 1995

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

Name: John Ketterer, M.D.

Address: Dept. Ob/GYn Dartmouth-Hitchcock Medical Center

One Medical Center Drive

City, State, Zip Code: Lebanon, NH 03756

Telephone: (603) 650-8163

How long and in what capacity has this individual known you? colleague 1995

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.

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: Paul D. Hanissian, M.D.

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. Paul D. Hanissian, M.D. was at Dartmouth-Hitchcock Medical Center

from 8/95- present to _____. During that time, he/she was

(List status in the Institution): Assistant Professor of 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:	____ Poor	____ Fair	____ Average	✓ Above Average
Professional judgment:	____ Poor	____ Fair	____ Average	✓ Above Average
Sense of responsibility	____ Poor	____ Fair	____ Average	✓ Above Average
Moral character/ ethical conduct:	____ Poor	____ Fair	____ Average	✓ Above Average
Competence and skill:	____ Poor	____ Fair	____ Average	✓ Above Average
Cooperativeness, ability to work with others:	____ Poor	____ Fair	____ Average	✓ Above Average
History & physical exam taking:	____ Poor	____ Fair	____ Average	✓ Above Average
Record keeping	____ Poor	____ Fair	____ Average	✓ Above Average
Case presentations:	____ Poor	____ Fair	____ Average	✓ Above Average
Patient management:	____ Poor	____ Fair	____ Average	✓ Above Average
Physician-Patient relationship:	____ Poor	____ Fair	____ Average	✓ Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	____ Poor	____ Fair	____ Average	✓ Above Average
Participation in Medical Staff Affairs	____ Poor	____ Fair	____ Average	✓ 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: Paul D. Hanissian, M.D.

How long have you known the applicant and in what capacity? 8/95 supervisory

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 consults 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.

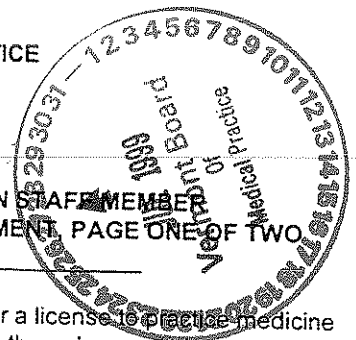
I recommend Paul D. Hanissian, M.D. for licensure in Vermont.
Name of Physician

Signed: Barry D Smith Date: 7/20/99

Print or Type Name and Title: Barry D. Smith, M.D. Chairman Ob/Gyn

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: Paul D. Hanissian, M.D.

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. Paul D. Hanissian was at Dartmouth-Hitchcock Medical Center

from 8/95- present to _____. During that time, he/she was

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

Reference Form #3
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: Paul D. Hanissian, M.D.

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 consults 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 Paul D. Hanissian, M.D. for licensure in Vermont.
Name of Physician

Signed: _____ Date: 7/26/99

Print or Type Name and Title: John Ketterer, M.D. Vice Chairman Ob/ Gyn

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: PATRICK B. HERSON

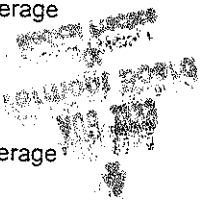
The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability 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. PATRICK B. HERSON was at DARTMOUTH-HITCHCOCK MEDICAL CENTER from 7/99 to Present. During that time, he/she was (List status in the Institution): ACTIVE STAFF.

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



Reference Form #3
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: PATRICK B. HERSON

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 consults 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: Review of references

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 PATRICK B. HERSON for licensure in Vermont.
Name of Physician

Signed: Donald O Kollisch MD Date: 8/24/99

Print or Type Name and Title: Donald Kollisch MD
Medical Director
Community Hlth Ctr.
DHMC
Medical Ctr. Dr.

SECTION IV

STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

Applicant's Statement Regarding Child Support

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

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

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

or

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

Applicant's Statement Regarding Taxes

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:**

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

Applicant's Statement Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renewal 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 two statements below regarding unemployment contributions or payments in lieu of unemployment contributions:**

X I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a $10,000.00 fine or both).

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.

Social Security #* [redacted] Date of Birth [redacted]

* The disclosure of your social security number is mandatory, is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training, in the administration of 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. I understand that providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant Paul Ham Date 7/20/95

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, PATRICK B. HERSON, 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: Patrick B Herson MD

Date: 8/24/99

Print or Type Name: PATRICK B. HERSON

Address: [redacted]

City, State, Zip Code: [redacted]

Telephone Number: (603) 650 - 4074

Subscribed and sworn to before me, this 24th day of August 1999.

Louise Carpenter
Notary Public

LOUISE B. CARPENTER
NOTARY PUBLIC
STATE OF NEW HAMPSHIRE
My commission expires Feb. 17, 2004

Affix Seal

My License Expires: _____

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

Women's Health for Life

Department of Obstetrics & Gynecology

One Medical Center Drive
Lebanon, New Hampshire 03756
603 650-8161 *Fax 603 650-6850*

August 20, 1999

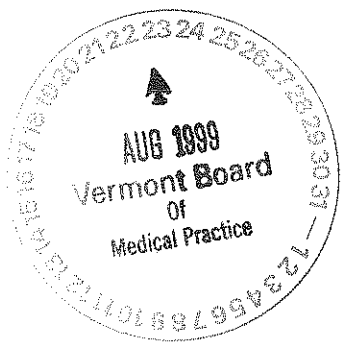
State of Vermont
Board of Medical Licensure
109 State Street
Montpelier, VT 05609-1106

To Whom It May Concern:

Enclosed please find the application for medical licensure for Vermont. Dr. Paul David Hanissian is applying for licensure. The $350 fee for processing will come under separate cover.

Thank you,

Inger Imset
(603) 650-8563



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

State of Vermont
Board of Medical Practice

paid 400.00

September 15, 1999

Paul David Hanissian
Dept. Of Obstetrics and Gynecology
Dartmouth-Hitchcock Medical Center
Lebanon, NH 03756

Dear Doctor Hanissian:

We are in receipt of your application for medical licensure in the State of Vermont. However, since you were sent the application package there has been a change made by Legislature regarding our fee schedule.

The change for Medical Doctor Licensure application is that the fee, effective July 1, 1999, is now $400.00. Therefore, you need to send another check for $50.00. Your application will not be complete until the remainder is received.

If you have any questions or wish to follow up on your application status please do not hesitate to contact this office.

Sincerely,

Kim Johnson
Staff Assistant

/kaj

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

State of Vermont

Board of Medical Practice

September 15, 1999

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Dept. Of Obstetrics and Gynecology
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Lebanon, NH 03756

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If you have any questions or wish to follow up on your application status please do not hesitate to contact this office.

Sincerely,

Kim Johnson
Staff Assistant

/kaj

National Board of Medical Examiners®

3750 MARKET STREET, PHILADELPHIA, PA 19104

TELEPHONE (215) 590-9500

08/05/99

EXAMINEE ID#:3-400-019-0

TO: Paul David Manissian, MD
Dartmouth-Hitchcock Medical Center
Dept of Obstetrics and Gynecology
LEBANON NH 03756

ID#: 3-400-019-0

FROM: Examinee Records Department

An endorsement of your certification by the National Board of Medical Examiners has been provided to the medical licensing authority in the state(s) shown below.

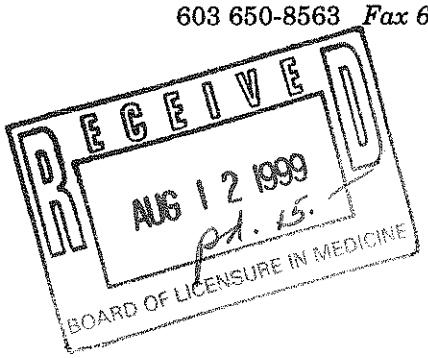
Please confirm with the state that your document has been received. If it has not, a duplicate will be provided to the state without charge if we are notified within three months from the date of this letter. Beyond that time, the fee of $40 will be charged for a replacement. Because of the high volume of processing, however, please allow 3-4 weeks for the state to record receipt of your endorsement.

1250

Vermont

Women's Health for Life
Department of Obstetrics & Gynecology
Office of the Chair

One Medical Center Drive
Lebanon, New Hampshire 03756
603 650-8563 *Fax 603 650-7795*



July 19, 1999

Maine Board of Licensure in Medicine
2 Bangor Street
137 State House Station
Augusta, ME 04333

To Whom It May Concern:

Enclosed please find the verification of certificate of medical licensure from the application for Vermont license. Dr. Paul David Hanissian is applying for licensure. Also enclosed is the $15.00 fee for processing. Please complete the form and return to:

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

Thank you,

Inger Imset

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

CERTIFICATE OF MEDICAL LICENSURE

This section must be completed by the regulatory authority in the states in which **you now hold or have ever held** a license to practice medicine.

I, _____ Secretary of the

_____ State Board of Medical Examiners, certify that

Paul D. Hanissian, M.D.

was granted Certificate Number 014040 to practice medicine in the

State of Maine on the

11 day of March, 19 97,

based on _____ and that said certificate has never been revoked,

suspended or conditioned in any way, or the licensee has never been disciplined by the Board in any way.

NOTE: If licensed by written examination the secretary should further certify:

I further certify that the aforesaid _____ in his/her written

examination before this Board, obtained a general average of _____ percent in the

following branches:

(The subjects of the examination and rating of each must be stated in full.)

_____

_____

_____

(AFFIX SEAL)

_____ _____
(Secretary/Director) (Date)

Women's Health for Life

Department of Obstetrics & Gynecology

Office of the Chair

One Medical Center Drive
Lebanon, New Hampshire 03756
603 650-8563 *Fax 603 650-7795*

July 19, 1999

State of New Hampshire
Board of Medicine
2 Industrial Park Drive
Concord, NH 03301

To Whom It May Concern:

Enclosed please find the verification of certificate of medical licensure from the application for Vermont license. Dr. Paul David Hanissian is applying for licensure. Also enclosed is the $10.00 fee for processing. Please complete the form and return to:

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

Thank you,

Inger Imset

Renewal - 042.0010038

Name	Paul David Hanissian
Credential	042.0010038

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 802-657-4220, 800-745-7371 or medicalboard@state.vt.us.

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

INSTRUCTIONS

- 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:
   Hanissian

2. First Name:
Paul

3. Middle Name:
David

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. Enter your MAILING ADDRESS information:

Attention DHMC Dept Obstetrics & Gynecology
Street One Medical Center Drive
City Lebanon **State** NH **Zip** 03756 **Country** United States
E-mail Address [redacted]
Telephone [redacted] **Alternate Phone (e.g. Pager)**

8. Enter your PUBLIC ACCESS address information:

Attention DHMC Dept Obstetrics & Gynecology
Street One Medical Center Drive
City Lebanon **State** NH **Zip** 03756
Country United States
Telephone (603) 650-8563
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
New Hampshire	MD	9485	07/05/1995	06/30/2013	Active

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: Robert Wood Johnson Medical School **State**: New Jersey **Country**: United States **School Type**: Medical School	05/31/1991

Degree: MD	

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
Maine Medical Center	01/01/1995	

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
Gynecology	American Board of Obstetrics and Gynecology	01/01/1997	01/01/2007
Gynecology	American Board of Obstetrics and Gynecology	01/01/2007	

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

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

Facility Name	State	Start Date
Mary Hitchcock Hospital (NH)	New Hampshire	
Cheshire Medical Center	New Hampshire	03/30/2009

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?

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 stipluations), 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 stipluations), 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.
No

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

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?
None reported	Lebenon	New Hampshire	Yes		Yes	Yes

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:
11/02/2012

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

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:

11/02/2012

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.

Self / Credit Card

Review

Renewal - 042.0010038

Name	Paul David Hanissian
Credential	042.0010038

Fee Details

Renewal	$500.00
	$500.00

Renewal Introduction

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

PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

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

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

INSTRUCTIONS

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

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

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

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

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

Thank you.

Renewal Part I

Name:
Indicate your full legal name (use no initials). If your name has changed at any time during your life and you are not using FCVS, you

must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Last Name:
   Hanissian

2. First Name:
   Paul

3. Middle Name:
   David

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
   paul.d.hanissian@hitchcock.org

8. Enter your MAILING ADDRESS information:

Attention DHMC Dept Obstetrics & Gynecology
Street One Medical Center Drive
City Lebanon **State** NH **Zip** 03756 **Country** United States
E-mail Address [redacted]
Telephone (603) 653-9312 **Alternate Phone (e.g. Pager)**

9. Enter your PUBLIC ACCESS address information:

Attention DHMC Dept Obstetrics & Gynecology
Street One Medical Center Drive
City Lebanon **State** NH **Zip** 03756
Country United States
Telephone (603) 653-9312
E-mail Address [redacted]
Alternate Phone (e.g. Pager)

Renewal Part II

10. Were you in active clinical practice in the past 12 months?
    No

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	9485	07/05/1995	06/30/2013	Active

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

School	Graduation Date
School Name: Robert Wood Johnson Medical School **State**: New Jersey **Country**: United States **School Type**: Medical School **Degree**: MD	05/31/1991

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
UMDNJ Robert Wood Johnson	05/22/1991	
Maine Medical Center	01/01/1995	

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
Gynecology	American Board of Obstetrics and Gynecology	01/01/1997	01/01/2007
Gynecology	American Board of Obstetrics and Gynecology	01/01/2007	

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

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

Facility Name	State	Start Date	End Date
Mary Hitchcock Hospital (NH)	New Hampshire		
Cheshire Medical Center	New Hampshire	03/30/2009	11/02/2012

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

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

19. State:

20. Year:

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

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

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

24. State:

25. Year:

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

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

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

No

29. State:

30. Year:

31. Circumstances:

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

33. Are you currently the subject of any disciplinary charges by, or has disciplinary or employment action ever been taken by, any governmental authority, hospital, health care facility, or professional medical association, other than matters that have already been identified in response to preceding questions. If yes, identify the entity bringing the charges or action, the date, the duration of any discipline or conditions, any action taken, and the circumstances in the following questions. Upload documents related to the charges or actions where indicated.

No

34. Name of entity involved:

35. Date:

36. Duration:

37. Action Taken (add all that apply):

38. Circumstances:

39. Disciplinary charges or actions - Upload documents:

40. Has any US or Canadian state, territorial, or provincial licensing board ever denied you the privilege of taking an examination to be licensed as a health care professional? If yes, identify the state, territory, or province that denied you the privilege and provide the circumstances of the denial in the following questions. Upload documents relating to the denial of the privilege of taking an examination where indicated.

No

41. State:

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

43. Denial of examination privileges - Upload documents:

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

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

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

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

48. Training program(s):

49. Location of program(s):

50. Year:

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

52. Are you currently the subject of an investigation or peer review by any licensing authority, hospital, medical staff group, health care facility, professional association, or other body that has authority to take actions regarding: your right to practice medicine or any other healing art; your employment practicing medicine or any other healing art; or your professional qualifications (e.g., specialty board certification)? If yes, provide the name of the entity conducting the investigation, its location, the date you learned about the investigation, and the circumstances that triggered the investigation in the following questions and upload any relevant documentation you have such as a letter notifying you of the investigation where indicated.
No

53. Entity Investigating:

54. Location of entity investigating:

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

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

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

58. Has your privilege to possess, dispense, administer, or prescribe controlled substances or other prescription medications or devices ever been suspended, revoked, denied, restricted, or surrendered as the result of an investigation or action by any governmental entity at any time? If yes, provide the entity that acted on your privilege to prescribe, the nature of the limitation or action, the date of the action, and a description of the circumstances underlying the action in the following questions, and upload any relevant documentation you have regarding the action where indicated.
No

59. Entity that took action on prescribing privileges:

60. Action taken:

61. Date of action taken regarding prescribing privileges:

62. Circumstances underlying action on prescribing rights:

63. Action taken on prescribing privileges – upload documents.

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

65. Court:

66. City and state:

67. Charge:

68. Description:

69. Status:

70. Date:

71. Defendant in criminal proceeding - Upload Documents:

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

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

Renewal Part III

PART III

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

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

74. To your knowledge, are you currently the subject of a criminal investigation that has not yet resulted in charges against you? If yes, provide the jurisdiction, a description of the matter under investigation, and the date you became aware of the investigation in the following questions.

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?

[redacted]

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?

[redacted]

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

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

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

93. Treating organization:

94. Address:

95. Telephone:

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

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

98. Dates of treatment (from, to):

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

100. Address:

101. Telephone:

102. Contact person at Program:

Renewal Part IV

Statutory Profile Questions

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

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

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

No

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

Date of Conviction	Court of Conviction	City	State	Description

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

No

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

Date of Charges	Court	City	State	Description of Charges

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

No

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

Date	Final Disposition Summary

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

No

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

Date of Disposition	Licensing Authority	City	State	Description of Disposition

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

111. Have you ever had hospital privileges revoked or involuntarily restricted for reasons related to competence or character?

No

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

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

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

resigned medical staff membership or privileges;

not renewed medical staff membership or privileges; or, -

consented to a restriction of hospital privileges?
No

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

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

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

- a court judgment against you; or

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

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

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

Date of Judgment	Number of Judgments

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

Date Of Settlement

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

Date

Appointments/Teaching [See 26 VSA § 1368(a)(12)]
Note: Providing the following Appointments and Teaching information is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

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

School	City	State	Nature of Appointment	Year Started	Year Ended

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

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

121. Publications [See 26 VSA § 1368(a)(13)]
Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web.

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

Title	Publication	Publication Date

122. Activities [See 26 VSA § 1368(a)(14)]
Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web.
Please provide information regarding your professional or community service activities and awards.

Activity or Award

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

Practice Name	City	State	Primary Practice	Languages	Accepts Medicaid?	Accepts New Medicaid Patients?
None reported	Lebenon	New Hampshire	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:

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

Yes

125. Date:
11/26/2014

Child Support, Taxes

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer these questions.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the

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

126. You must select one of the two statements below regarding child support regardless whether or not you have children:
I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

Regarding Taxes

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

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

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

128. Social Security Number:
[redacted]

129. Date of Birth:
[redacted]

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

131. Date:
11/26/2014

Continuing Medical Education Requirements

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

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

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

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

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

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

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

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

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

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