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

Office Location:
One Prospect Street
Montpelier, VT 05602

State of Vermont
Board of Medical Practice

June 6, 2002

Anne Hildreth, PA-C
[redacted]

RE: Physician's Assistant Certification
55-0030584

Dear Anne:

Congratulations! On June 5, 2002, you were presented and approved for certification as a Physician's Assistant in the State of Vermont. Enclosed is your printed certificate. A professional certificate has been sent to your employer. This is to be placed at your place of employment, to be visible for the public.

Physician's Assistant certifications are renewed in January of every even year (no matter when you received your initial certification). You will be sent a renewal form two months prior to the expiration date.

If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

Jenny

Jenny M. Audet
Administrative Assistant

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

cc: Cheryl Gibson, M.D.

Enclosure

STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

PROFESSIONAL CERTIFICATE

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

Anne Sarver Hildreth, PA-C
P.A. Certification Number: 55-0030584
Valid only while working under the supervision of Cherly Gibson, M.D. and Susan Smith, M.D., at Planned Parenthood of Northern New England, 23 Mansfield Avenue, Burlington, VT.
Valid through January 31, 2004.

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

VERMONT BOARD OF MEDICAL PRACTICE

at Montpelier, in the county of Washington, State of Vermont,

this 6th of June , A.D. 2002

Jenny Audet
Administrative Assistant

Jenny Audet

From: Katherine Silta <katherine.silta@cvosm.org>
To: Jenny Audet (E-mail) <jaudet@medbd.state.vt.us>
Sent: Thursday, May 30, 2002 12:23 PM
Subject: PA's

Hildreth and Bradley are all set. KAS

Ann Hildreth
#055-0030584
May 31, 2002

Jenny Audet

From: Katherine Silta <katherine.silta@cvosm.org>
To: Jenny Audet (E-mail) <jaudet@medbd.state.vt.us>
Sent: Wednesday, May 08, 2002 12:26 PM
Subject: PA's

You can issue numbers to Krall,Allen,Potter. Hildreth showed up over an hour late and rescheduled for interview....again. Cassie

MEMORANDUM

TO: Cassie Silta, PA Board Member

FROM: Jenny M. Audet, Administrative Assistant Jenny

DATE: February 5, 2002

SUBJECT: Anne Hildreth, PA-C

****

Enclosed is a complete file on Anne Hildreth, PA-C who will be employed by Planned Parenthood of Northern New England, 23 Mansfield Avenue, Burlington, VT.

She has **not** held other licenses in Vermont. Her supervisors will be Cheryl Gibson, MD and Susan Smith, MD.

If you require any further information please feel free to contact me. Thanks.

/jma

Enclosure

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

Office Location:
One Prospect Street
Montpelier, VT 05602

State of Vermont
Board of Medical Practice

February 5, 2002

Anne Hildreth PA-C
[redacted]

Dear Anne:

Your PA application file to work at Planned Parenthood of New England in Burlington, VT appears to be complete.

I have mailed a copy of your application file to the PA Board member Cassie Silta. She will review your application, with particular emphasis on the Scope of Practice. She will than contact you to set up an interview time that is convenient for both of you.

Once you have interviewed and she is satisfied with the results she will contact me to issue you a certificate number. I will notify you immediately and you can begin work. Your paper certificate will be mailed after the next Board Meeting, which held the first Wednesday of each month.

If you have any questions please feel free to contact me at (802) 828-2422.

Sincerely,

Jenny Audet

Jenny Audet
Administrative Assistant

PHYSICIAN ASSISTANT STATUS SHEET

DATE RECEIVED: 01/12/01

NAME: Anne Sarver Hildreth PHONE #: [redacted]

ADDRESS: [redacted]

EMPLOYER: Planned Parenthood of Northern New England

ADDRESS: 23 Mansfield Avenue, Burlington, VT 05401

Initial License in Vermont? X Yes ____ No Application Fee Paid $ 75.00

X Completed Application for Certification as a Physician Assistant in Vermont (Signed & dated)

X Certified Copy of Birth Certificate DOB [redacted]

X Employment Contract

X Primary Supervisor Physician Application (Signed by PA & Supervisor)
M.D.: Cheryl Gibson Lic #: 42-7465

X Secondary Supervising Physician Applications
M.D.: Susan Smith Lic #: 42-5990

M.D.: ____ Lic #: ____

M.D.: ____ Lic #: ____

M.D.: ____ Lic #: ____

M.D.: ____ Lic #: ____

X Direct Verification of State Licensure
X Massachusetts Rec'd
X New Hampshire Rec'd

Scope of Practice (signed by PA and Primary Supervisor) A detailed description Of the duties and scope of practice to include authority to prescribe medications.

N/A For University trained applicants:
X A. Direct Verification: Certificate of Physician Assistant Education Hahnemann University 6/10/82 Rec'd
X B. Direct Verification: Proof of satisfactorily completing the certification examination given by NCCPA (National Commission on the Certification of Physician Assistants) from NCCPA. Rec'd

___ For Vermont Apprenticeship trained applicants:
___ A. Documentation from the physician in charge of the applicant's Board-approved apprenticeship program that the applicant has satisfactorily completed the program.
___ B. Final PA trainee evaluation conducted by the Board ensuring that the applicant is qualified by education, training and experience to perform the duties outlined in his/her scope of practice.

Rec'd 1-23-02

X Two (2) completed reference forms mailed directly to the Board by the Physician.
X Physician Reference Form Number 1 ~~Judith Tyson~~, MD Cheryl Gibson MD
X Physician Reference Form Number 2 Cheryl Gibson, MD Susan Smith MD

N/A Completed Form A. if applicant answered "yes" in Section III

X Child Support/Tax/Unemployment Form ____ Federation Disciplinary C

pd

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

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

FEE: Enclose a check in the amount of $ 75.- initial certification ($50 if not initial) made payable to the Vermont Board of Medical Practice.

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

SECTION I

Name: HILDRETH ANNE SARVER
(Last) (First) (Middle) (Former)

Mailing Address: [redacted]
(City) (State) (Zip Code) (Phone)

Office Address: 5 Dunning ST
(Street)

Claremont NH 03743 603-542-4568
(City) (State) (Zip Code) (Phone)

Home Address: [redacted]

City, State, Zip Code: [redacted]

Daytime Telephone Number: (603) 542-4568

Date of Birth: Month: [redacted] Day [redacted] Year [redacted]

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

Basis for Licensure: X University Trained - NCCPA Examination

____ Vermont Apprenticeship Trained

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

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

Name as it should appear on your certification: Anne Sarver HILDRETH

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 certified / licensed elsewhere: N/A

EDUCATION (College Forward)

(Name and location of Institution)	(From/To-Month/Year)	(Degree)
Hahnemann Univ. Phila, Pa.	1980-1982	AS/PA cert.

SUPERVISING PHYSICIANS

List name and specialty of supervising physician(s):

Supervisor's Name	Supervisor's Specialty
Dr. Cheryl Gibson	OB/Gyn
Dr. Susan Smith	OB/Gyn

List name and specialty of secondary supervising physician(s):

Secondary Supervising Physician(s)	Secondary Supervising Physician's Specialty
as above	

PRACTICE

Have you ever held a Vermont Temporary Certification? ____ Yes X No If Yes, when: _____

Do you have hospital privileges? _____ Yes X No
List all hospitals where you have, or previously have had, privileges - include name, address, and dates:

NAME	ADDRESS	FROM/TO	SPECIALTY

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

TRAINING

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

Name	Address	From/To	Training

List all other significant training affecting your work as a physician's assistant
(e.g., courses in such areas as laboratory or x-ray technology, physical therapy, EMT):

_____

_____

OTHER LICENSES OR CERTIFICATIONS

Do you hold, or have you ever held, a license/certification in any other state? X Yes ____ No If yes, complete the section below and send a Verification of Physician's Assistant Licensure or Certification to each state.

State	Certificate/License Number	Date Issued	Status (Active or Inactive)
Mass.	—	—	never used
I was planning on moving there.			Inactive
In 1994 - got the license; never moved / it expired			

Are you a graduate of a program accredited by the Committee on Allied Health Education and Accreditation (CAHEA) or its successor agency? X Yes ____ No

Do you hold a NCCPA Certificate? X Yes ____ No If yes, attach a copy.

NCCPA Certificate Number: 101311 Expiration Date: 6/1/01

When are you scheduled to begin work in Vermont? ASAP

Have you previously applied for certification in Vermont? ____ Yes X No
If yes: Under what name _____ Year _____

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

Norwich N.H. 1984 - 1992

1992 - 2000 → S. Thetford, VT

Have you ever discontinued your practice as a physician's assistant or physician's assistant trainee for a period of more than six months? ____ Yes X No If yes, explain: _____

_____

_____

_____

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

SECTION II

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

PHOTOGRAPH

SECTION III

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

1. Have you ever applied for and been denied a certification/license to practice as a PA or any healing art?____Yes _X_ No

2. Have you ever withdrawn an application for a certification/license to practice as a PA or any healing art?____ Yes _X_No

3. Have you ever voluntarily surrendered or resigned a certification/license to practice as a PA or any healing art in lieu of disciplinary action? ____Yes _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 PA 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)? ____Yes _X_No

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]

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

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

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

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 as a PA 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 as a PA 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]

Anne Hilder PA-C

EMPLOYMENT CONTRACT

I, Anne Hildreth, an applicant for
(Applicant's Name)

Certification as a Physician's Assistant, am employed by

Planned Parenthood of NO. New England
(Employer's Name)

for the period beginning 8/24/99
(Month/Day/Year)

Termination of my contract will cause my Certification to become null and void.

Anne Hildreth PAC
Signature of Physician's Assistant

11/27/00
(Date)

Cheryl Gibson
Signature of Supervising Physician

11/27/00
(Date)

Print Name of Physician: Cheryl Gibson

NOTE: A contract from each separate employer is required.

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

RECEIVED
DEC - 4 2000
VERMONT BOARD OF MEDICAL PRACTICE

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Gibson (Last) Cheryl (First) A (Middle)

Mailing Address Planned Parenthood (Office Name)

23 Mansfield Ave. (Street)

Burlington, VT. 05401 (City/State) (Zip Code) 863-9001 (Telephone Number)

Vermont License Number: 042-0007465 Number of years you have been practicing medicine: _____

Hospital(s) where you have privileges	Hospital(s) Location	Specialty
FAHC	Burlington, VT.	OB/Gyn

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

Amy Bergman - Barre P.P
August Burns - Hyde Park P.P
Sue Burton - Burl P.P (over please)

What arrangements have you made for supervision when you are not available or out of town:

24 hour on-call system

CERTIFICATE OF SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Annesarven Hildreth, P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician's assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.

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

11/27/00 (Date)

X [signature] MD (Signature of Supervising Physician)

Co-signature of PA: [signature] PAC

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number: MH0 195986

RECEIVED
DEC - 4 2000
VERMONT BOARD OF MEDICAL PRACTICE

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Smith Susan
(Last) (First) (Middle)

Mailing Address Planned Parenthood
(Office Name)
23 Mansfield Ave.
(Street)
Burl, VT. 05401 863-9001
(City/State) (Zip Code) (Telephone Number)

Vermont License Number: 042-0005990 Number of years you have been practicing medicine: _____

Hospital(s) where you have privileges	Hospital(s) Location	Specialty
FAHC	Burlington, VT.	OB/Gyn

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

Amy Boroman - Barre P.P
August Burns - Hyde Park P.P
Sue Burton - Burl P.P (OEP)

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

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

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

_____ (Date)

Susan Smith (Signature of Secondary Supervising Physician)

Reference Form #1
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 PHYSICIAN WORKED WITH MOST RECENTLY, PAGE ONE OF TWO

Name of Applicant: Anne Hildreth

The physician's assistant named above has applied to the Vermont Board of Medical Practice for a certification to practice as a physician's assistant 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.

Name Anne Hildreth was at Planned Parenthood

from 3/9/94 to present. During that time, he/she

was (List status in the Institution): Physician Assistant

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. Note: our ratings are satisfactory, equivalent to average - to above average.

The basic medical knowledge to be expected in a P.A.	___ 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 skills in the tasks delegated:	___ Poor	___ Fair	✓ Average	___ Above Average
Cooperativeness, ability to work with others	___ Poor	___ Fair	✓ Average	___ Above Average
Willingness to accept directions and limitations in role:	___ Poor	___ Fair	✓ Average	___ Above Average
History & physical exam taking:	___ Poor	___ Fair	✓ Average	___ Above Average
Record keeping:	___ Poor	___ Fair	✓ Average	___ Above Average
Patient management:	___ Poor	___ Fair	✓ Average	___ Above Average
P.A.-Patient relationship:	___ Poor	___ Fair	✓ Average	___ Above Average
Track record in adhering to scope of practice:	___ Poor	___ Fair	✓ Average	___ Above Average
Ability to communicate in reading, writing & speaking the English language:	___ Poor	___ Fair	✓ Average	___ Above Average

Reference Form #1
Continued

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

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY
PAGE TWO OF TWO

Name of Applicant: Anne Hildreth

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 as a physician's assistant? ____ 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? ____ 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 concern (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 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 previous evaluations
____ Other - Specify: clinical evaluations

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

I recommend Anne Hildreth for licensure in Vermont.
Name of Physician's Assistant

Signed: [signature] Date: 1/17/02

Print or Type Name and Title: Cheryl Gibson, M.D

Reference Form #2
Return Directly to Board

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

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH RECENTLY
PAGE ONE OF TWO

Name of Applicant: Anne Hildreth

The physician's assistant named above has applied to the Vermont Board of Medical Practice for a certification 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.

Name: Ann Hildreth was at Planned Parenthood

from 3/9/94 to Present. During that time, he/she was

(List status in the institution): Physician Assistant

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. Note: our ratings are satisfactory, equivalent to average - above average.

The basic medical knowledge to be expected in a P.A.	___ 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 skills in the tasks delegated:	___ Poor	___ Fair	✓ Average	___ Above Average
Cooperativeness, ability to work with others	___ Poor	___ Fair	✓ Average	___ Above Average
Willingness to accept directions and limitations in role:	___ Poor	___ Fair	✓ Average	___ Above Average
History & physical exam taking:	___ Poor	___ Fair	✓ Average	___ Above Average
Record keeping:	___ Poor	___ Fair	✓ Average	___ Above Average
Patient management:	___ Poor	___ Fair	✓ Average	___ Above Average
P.A.-Patient relationship:	___ Poor	___ Fair	✓ Average	___ Above Average
Track record in adhering to scope of practice:	___ Poor	___ Fair	✓ Average	___ Above Average
Ability to communicate in reading, writing & speaking the English language:	___ Poor	___ Fair	✓ Average	___ Above Average

Reference Form #2
Continued

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

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH RECENTLY
PAGE TWO OF TWO

Name of Applicant: Anne Hildreth

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? X 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 as a physician's assistant? ___ Yes X No

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

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? ___ Yes X 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 X No

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

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

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

Does the applicant call upon consults when needed? X 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 previous evaluations
X Other - Specify: clinical Evaluations @

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

I recommend Anne Hildreth for licensure in Vermont.
Name of Physician's Assistant

Signed: Susan Smith Date: 1/15/02

Print or Type Name and Title: Susan Smith

NCCPA

National Commission on Certification of Physician Assistants

December 21, 2001

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

RE: Anne Sarver Hildreth, PA-C

To Whom It May Concern:

Anne Sarver Hildreth is currently certified by the NCCPA and holds certificate no.1011311.

Initial certification was granted on January 15, 1983. Anne Sarver Hildreth will remain certified by NCCPA until December 31, 2003.

If you have any questions regarding the information provided in this report, please contact us at the number below. To receive information about NCCPA's certification requirements and policies via our free fax on demand service, call 770.734.4500, select option 6 from the main menu and request document # 101, *Certification Maintenance Guidelines.* Or visit our web site, www.nccpa.net.

Sincerely,

Ragan Morrow

Ragan Morrow,
Director of Certification Maintenance

RECEIVED
DEC 26 2001
VERMONT BOARD OF MEDICAL PRACTICE

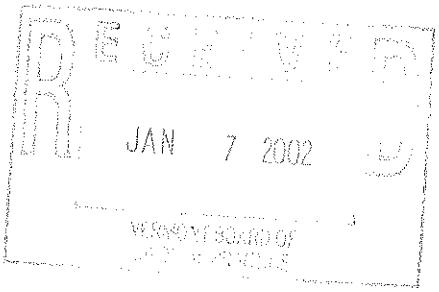
The official NCCPA seal is affixed above on the original of this document.

Suite 800 · 157 Technology Parkway · Norcross · Georgia · 30092 · Tel: 770.734.4500 · Fax: 770.734.4535 · Web: www.nccpa.net

MCP Hahnemann University

Operated by

College of Nursing and Health Professions
Physician Assistant Program
Advanced Physician Assistant Studies Program
Mail Stop 504 • 245 N. 15th Street • Philadelphia, PA 19102-1192
TEL 215.762.7135 • **FAX** 215.762.1164
www.mcphu.edu



03 January 2002

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

IN RE: ANNE HILDRETH, PA-C

To whom it may concern:

This letter serves to verify that Ms. Anne Hildreth matriculated into the MCP Hahnemann University Physician Assistant Program on September 2, 1980. She successfully completed the program o June 10, 1982.

If further information is desire, please do not hesitate to contact me.

Sincerely,

Patrick C. Auth, Ph-C, MS, PA-C
Assistant Professor and Director
Physician Assistant Program

Commonwealth of Massachusetts
Division of Professional Licensure
(Formerly Division of Registration)
239 Causeway Street • Boston, Massachusetts 02114

JANE SWIFT
GOVERNOR

JENNIFER DAVIS CAREY
OFFICE OF CONSUMER AFFAIRS

WILLIAM G. WOOD
DIRECTOR

Board of Registration of Physician Assistants
phone # (617) 727-3069

Certified Statement of Registration

December 28, 2001

The individual named below is in good standing in the Commonwealth of Massachusetts as a licensed ***Physician Assistant***

Name: **Anne S. Hildreth**
License No.: **574**
Original Issue Date: **January 4, 1994**
Expiration Date: **March 1, 1995**

Gladys M. Clifton
Board Administrator
Board of Registration of Physician Assistants

SEAL

Registration verification can be obtained over the Internet:
www.state.ma.us/reg/boards/ap

The information provided in this "Certified Statement" is based on the records maintained by the Massachusetts Division of Professional Licensure and its licensing boards. Individuals are deemed to be in good standing if their license is current and not subject to any disciplinary status on the date of issuance of the "Certified Statement." Disciplinary status is defined as voluntary surrender, revocation, suspension, or probation of a license.

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DEC 31 2001
VERMONT BOARD OF
MEDICAL PRACTICE

State of New Hampshire

2 Industrial Park Drive, Suite 8

Concord, NH 03301-8520

(603) 271-6936

RECEIVED
JAN 14 2002
VERMONT BOARD OF MEDICAL PRACTICE

Verification Report

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

Licensee: ANNE S HILDRETH

Specialty: PA PHYSICIAN ASSISTANT

License Number: 0084

Issue Date: 10/24/83

Expiration Date: 12/31/02

Disciplinary Action: NONE

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

Steve Sain

Secretary

01-10-02

Date

SEAL

SECTION IV

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

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

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:

____ 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 [signature] Date 12/4/00

PHYSICIAN'S ASSISTANT SCOPE OF PRACTICE
at Planned Parenthood of Northern New England

Planned Parenthood of Northern New England's Scope of Practice for Physician's Assistants consists of several documents:

1) PPNNE Standing Orders: Each P.A. practitioner annually signs the Standing Orders that are approved by PPNNE's Medical Advisory Committee then co-signed by PPNNE's Medical Director. Standing Orders define the prescriptive and medical authority of the P.A. practitioner at PPNNE.

2) PPNNE's Medical Protocol: The exact duties of the P.A. are clearly defined in PPNNE's Medical Protocol, a copy of which is on file with the Vermont Board of Medical Practice.

3) Medical Oversight at PPNNE: Please refer to the attached document, Medical Oversight at PPNNE, for information about the structure of supervision of P.A.'s at PPNNE.

4) Additional information about PPNNE's health centers, patient population and P.A. practice at Planned Parenthood of Northern New England:

Planned Parenthood of Northern New England is a non-profit health care organization with fifteen outpatient health centers in Vermont. Under the supervision of PPNNE's Medical Director, Physician's Assistants at PPNNE health centers provide outpatient gynelogical and preventive care for women and men as outlined in PPNNE's Standing Orders and Medical Protocols.

Many of our sites are located in rural areas where access to health care may be difficult. PPNNE offers a sliding fee scale based on the individual's ability to pay. Our commitment to providing services regardless of a client's ability to pay means that thousands of Vermonters without health insurance have access to high quality reproductive and preventive health care.

While the majority of our clients are between the ages of 20 and 34, 27% of our patients are teenagers, and 15% are over 35 years old. In addition, many of our clients are economically disadvantaged.

As specified in Section I, Part I of the PPNNE Medical Protocol, each clinic site is

required to inform patients how to obtain care in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinic as well as the medical back-up arrangements with a physician or hospital.

PPNNE's P.A. Practitioners do not independently prescribe or dispense controlled substances and therefore, do not have DEA numbers.

State of New Hampshire

2 Industrial Park Drive, Suite 8

Concord, NH 03301-8520

(603) 271-6936

RECEIVED
JAN 25 2001
BUREAU OF MEDICAL POLICY

Verification Report

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

Licensee: ANNE S HILDRETH

Specialty: PA PHYSICIAN ASSISTANT

License Number: 0084

Issue Date: 10/24/1983

Expiration Date: 12/31/2001

Disciplinary Action: NONE

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

Sharon Carney

Secretary

1/22/01

Date

SEAL

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

DEC 18 2000

CERTIFICATE OF PHYSICIAN'S ASSISTANT EDUCATION

To be completed by an officer of your University

I hereby certify that Anne SARVER HILDRETH was admitted to the
(Name)

Hahnemann university (presently MCP Hahnemann University) Physician's Assistant

Program in Phila Pa. on
(City and State)

Sept. 2, 1980
(Date)

and completed all requirements for graduation on June 10, 1982.
(Date)

A Physician Assistant certificate was granted on June 10, 1982.
(Specify certificate/diploma/degree) (Date)

Is this program CAHEA or successor agency approved? XXX Yes _____ No

(AFFIX SEAL)

Date: 12 December 2000

Signed: Patrick C. Auth MS PAC
(Authorized Officer of the School)
Patrick C. Auth, MS, PA-C, Program Director

TO PROGRAM: Return to above address

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

LIST OF TWO REFERENCES

The Board rules require that references be from allopathic or osteopathic physicians with whom the applicant has worked recently, including one from the most recent primary supervisor. If the applicant has recently graduated from a Board-approved physician's assistant program, one must be from the Director of the program. If the applicant has recently completed a Board-approved apprenticeship program, one must be from the primary training physician.

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.

Names, addresses and telephone numbers of two references:

1) Reference #1 - Name of a Physician: Dr. Judy Tyson

Address: [redacted]

City, State

Telephone

How long has this individual known you? about 15 years

2) Reference #2 - Name of Physician: Dr. Cheryl Gibson

Address: c/o Women's Choice - PPNDE
23 Mansfield, Ave.

City, State, Zip Code: Burlington, VT. 05401

Telephone: (802) 863-9001

How long has this individual known you? about 5 years

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, Anne Salver Hildreth, HEREBY AUTHORIZE YOU to furnish to
(Name of Applicant)

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 professional experience and qualifications, my licensing history, my practice as a physician's assistant, 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 certification.

Signature: Anne Hildreth

Date: 12/4/00

Print or Type Name: ANNE HILDRETH

Address: [redacted]

City, State [redacted]

Telephone [redacted]

Subscribed and sworn to before me, this 12 day of December,

Luana Wilson-Reynolds
Notary Public

A CONFORMED COPY, ATTEST Luana Wilson-Reynolds
Notary Public

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

LUANA WILSON-REYNOLDS, Notary Public
My Commission Expires November 6, 2002

Reference Form #1
Return Directly to Board

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

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FEB 7 2001
VERMONT BOARD OF MEDICAL PRACTICE

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY, PAGE ONE OF TWO

Name of Applicant: Anne Hildreth

The physician's assistant named above has applied to the Vermont Board of Medical Practice for a certification to practice as a physician's assistant 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.

Name Anne Hildreth ~~was~~ is at P.A

from 8/24/89 to Present. During that time, he/she was (List status in the Institution): P.A / Planned Parenthood.

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.

The basic medical knowledge to be expected in a P.A.	____ 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 skills in the tasks delegated:	____ Poor	____ Fair	____ Average	✓ Above Average
Cooperativeness, ability to work with others	____ Poor	____ Fair	____ Average	✓ Above Average
Willingness to accept directions and limitations in role:	____ Poor	____ Fair	____ Average	✓ Above Average
History & physical exam taking:	____ Poor	____ Fair	____ Average	✓ Above Average
Record keeping:	____ Poor	____ Fair	____ Average	✓ Above Average
Patient management:	____ Poor	____ Fair	____ Average	✓ Above Average
P.A.-Patient relationship:	____ Poor	____ Fair	____ Average	✓ Above Average
Track record in adhering to scope of practice:	____ Poor	____ Fair	____ Average	✓ Above Average
Ability to communicate in reading, writing & speaking the English language:	____ Poor	____ Fair	____ Average	✓ Above Average

Reference Form #1
Continued

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

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY
PAGE TWO OF TWO

Name of Applicant: Anne Hildreth

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 as a physician's assistant? ____ 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? ____ 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 concern (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 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 previous evaluations
____ Other - Specify: ____

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

I recommend Anne Hildreth for licensure in Vermont.
Name of Physician's Assistant

Signed: X [signature] Date: 1/15/01

Print or Type Name and Title: Cheryl Gibson

Reference Form #2
Return Directly to Board

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

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DEC 19 2000
VERMONT BOARD OF MEDICAL PRACTICE

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH RECENTLY
PAGE ONE OF TWO

Name of Applicant: Anne Hildreth

The physician's assistant named above has applied to the Vermont Board of Medical Practice for a certification 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.

Name: Anne Hildreth was at Planned Parenthood of Northern ~~New England~~

from April '89 to present. During that time, he/she was

(List status in the Institution): a Physician Assistant.

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.

The basic medical knowledge to be expected in a P.A.	____ 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 skills in the tasks delegated:	____ Poor	____ Fair	____ Average	✓ Above Average
Cooperativeness, ability to work with others	____ Poor	____ Fair	____ Average	✓ Above Average
Willingness to accept directions and limitations in role:	____ Poor	____ Fair	____ Average	✓ Above Average
History & physical exam taking:	____ Poor	____ Fair	____ Average	✓ Above Average
Record keeping:	____ Poor	____ Fair	____ Average	✓ Above Average
Patient management:	____ Poor	____ Fair	____ Average	✓ Above Average
P.A.-Patient relationship:	____ Poor	____ Fair	____ Average	✓ Above Average
Track record in adhering to scope of practice:	____ Poor	____ Fair	____ Average	✓ Above Average
Ability to communicate in reading, writing & speaking the English language:	____ Poor	____ Fair	____ Average	✓ Above Average

Reference Form #2
Continued

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
109 STATE STREET
MONTPELIER, VERMONT 05609-1106
(802) 828-2673
REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH RECENTLY
PAGE TWO OF TWO

Name of Applicant: Anne Hildreth

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 as a physician's assistant? ____ 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? ____ 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 concern (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 previous evaluations
- ____ Other - Specify: ____

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

I recommend Anne Hildreth for licensure in Vermont.
Name of Physician's Assistant

Signed: Judith Tyson, MD Date: 12/14/2000

Print or Type Name and Title: Judith Tyson, M.D.
Medical Director (retired 7/31/2000)
Planned Parenthood of Northern New England

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, Anne Sawyer Hildreth, HEREBY AUTHORIZE YOU to furnish to
(Name of Applicant)

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 professional experience and qualifications, my licensing history, my practice as a physician's assistant, 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 certification.

Signature: Anne Hildreth PAC

Date: 12/4/00

Print or Type Name: ANNE HILDRETH

Address: [redacted]

City, State, Zip Code [redacted]

Telephone Number: [redacted]

Subscribed and sworn to before me, this 4th day of Dec,

Luana Wilson-Reynolds
Notary Public

A CONFORMED COPY, ATTEST Luana Wilson-Reynolds
Notary Public

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

LUANA WILSON-REYNOLDS, Notary Public
My Commission Expires November 6, 2002

State of New Hampshire
BOARD OF REGISTRATION IN MEDICINE
ANNE S HILDRETH, PA

License #: 0084 P

Issued: 10/24/1983

is entitled to practice for the year ending
12/31/2001

NATIONAL COMMISSION
ON
CERTIFICATION OF PHYSICIAN ASSISTANTS, INC.

Anne Sarver Hildreth

has successfully completed all requirements
to achieve or maintain NCCPA certification

Certificate Number: 1011311
Expiration Date: June 1, 2001

Executive Vice President

This card is for identification purposes only and does not constitute proof of certification. For verification, please contact NCCPA.

RECEIVED
DEC 19 2000
VERMONT BOARD OF MEDICAL PRACTICE

FORM B

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

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1) I, Anne Salver Hildreth, HEREBY AUTHORIZE YOU to furnish to
(Name of Applicant)

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 professional experience and qualifications, my licensing history, my practice as a physician's assistant, 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.

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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 certification.

Signature: Anne Hildreth

Date: 12/14/00

Print or Type Name: ANNE HILDRETH

Address: [redacted]

City, State, Zip Cod[redacted]

Telephone Numbe[redacted]

Subscribed and sworn to before me, this 12 day of December,

Luana Wilson-Reynolds
Notary Public

A CONFORMED COPY, ATTEST Luana Wilson-Reynolds
Notary Public

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

LUANA WILSON-REYNOLDS, Notary Public
My Commission Expires November 6, 2002

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

APPLICATION FOR CERTIFICATION AS A PHYSICIAN'S ASSISTANT
INSTRUCTIONS AND CHECKLIST, PAGE ONE OF TWO

- Thank you for your interest in physician's assistant (PA) certification in Vermont.
- Enclosed please find the application for certification. **If you require an application status update, please telephone the office.** It takes **a minimum of six weeks** to complete the process if there is nothing in the application requiring further Board review.
- **Any applicant with a disability** who needs an accommodation should contact the Board office.
- **The following is a list of documents required (Unless noted, a copy of the original, if applicable--is required to be submitted):**

1) ____ **Fee of $75. if initial PA certification ($50 if not initial).** Check made payable to the Vermont Board of Medical Practice.

2) ✓ **Completed APPLICATION** FOR CERTIFICATION AS A PHYSICIAN'S ASSISTANT IN VERMONT.

3) ____ **Certified** copy of **Birth Certificate**.

4) ____ **Copy of your employment contract. We have enclosed an employment contract form should you wish to use it.**

5) ✓ **PRIMARY SUPERVISING PHYSICIAN APPLICATION must be completed by your primary supervising physician and returned directly to this office.** The Board may invite the supervising physician to an interview if the Board has not previously reviewed the system of care delivery in which you propose to practice.

Rec'd

6) ✓ **SECONDARY SUPERVISING PHYSICIAN APPLICATION** from any secondary supervising physician(s).

7) ✓ **VERIFICATION OF PHYSICIAN'S ASSISTANT LICENSURE OR CERTIFICATION must be completed by the Licensing Board of each state where you now or have ever been allowed to practice as a physician's assistant.** Copies of certifications or licenses are not accepted.

Sent 12/14

8) ✓ **For University trained applicants:**

Sent 12/14

____ A. A **Certificate of Physician's Assistant Education** must be completed by your University.

____ B. Proof of satisfactorily completing the certification examination given by NCCPA (National Commission on the Certification of Physician's Assistants) from NCCPA. - **To be sent directly to this office from the Examining Agency.**

9) ✓ **For Vermont Apprenticeship trained applicants:**

____ A. Documentation from the physician in charge of your Board-approved apprenticeship program that you have satisfactorily completed the program.

____ B. Submit final PA trainee evaluation conducted by the Board to ensure that you are qualified by education, training and experience to perform the duties outlined in your scope of practice.

10) ✓ **Scope of Practice** (See attached definition): A detailed description of the duties and scope of practice delegated to you by your supervising physician including authority to prescribe medications.

11) ____ **Two (2) Completed Reference Forms** mailed directly to the Board **by the physician.**

Planned Parenthood®
of Northern New England

SERVING MAINE, NEW HAMPSHIRE AND VERMONT

CENTRAL OFFICE
183 Talcott Road, Suite 101
Williston, VT
05495-2075
Phone 802.878.7232
Fax 802.878.8001

MAR 1

March 5, 2001

Vermont Board of Medical Practice
Attn: Janice Fifield
109 State Street
Montpelier, VT 05609-1106

Dear Janice,

Enclosed you will find the primary and secondary supervising physician applications to attach to Anne Hildreth's Physician Assistants application, that was previously mailed to you.

Please call me at (802) 878-7716 x 241, if you have any questions.

Beverly Dion
Credentialing Coordinator

Enc.

Printed on Recycled Paper

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full: Gibson (Last) Cheryl (First) A (Middle)

Mailing Address: Planned Parenthood of No. New England (Office Name)
183 Talcott Road (Street)
Williston, VT. 05495 (802) 878-7232
(City/State) (Zip Code) (Telephone Number)

Vermont License Number: 042-0007465 Number of years you have been practicing medicine: ____

Hospital(s) where you have privileges	Hospital(s) Location	Specialty
Fletcher Allen	Burlington, VT	OB/Gyn

List all physician's assistants names and addresses you currently supervise: Mary Wallmyn - PP VUHC
Amy Bergman - PP, Barre, Barbara Nolfi - PP Burl.
August Burns - PP Hyde Park Judy Wechsler. PP Williston
Sue Burton - PP Burlington Cate Nicholas PP VUHC
Johanna Hauser - PP Burlington Katra Kindar PP VUHC

What arrangements have you made for supervision when you are not available or out of town: ____
24 Hour on-call Service

CERTIFICATE OF SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Anne Hildreth, P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician's assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.

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

2/26/01
(Date)

X [signature]
(Signature of Supervising Physician)

Co-signature of PA: [signature]

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number: MH195968

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Smith (Last) Susan (First) (Middle)

Mailing Address Planned Parenthood (Office Name)

183 Talcott RD. (Street)

Williston, VT 05495 (802) 878-7232
(City/State) (Zip Code) (Telephone Number)

Vermont License Number 042000590 Number of years you have been practicing medicine: _____

Hospital(s) where you have privileges	Hospital(s) Location	Specialty
Fletcher Allen	Burlington, VT	OB/Gyn

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

Amy Borgman P.P Barre
August Burns P.P Hyde Park
Sue Burton P.P Burlington (over)

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

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

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

2/26/01
(Date)

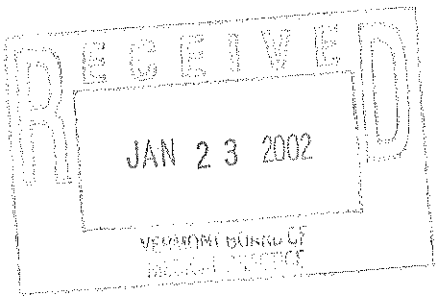
Susan Smith MD
(Signature of Secondary Supervising Physician)

Planned Parenthood®
of Northern New England

SERVING MAINE, NEW HAMPSHIRE AND VERMONT

CENTRAL OFFICE
183 Talcott Road, Suite 101
Williston, VT
05495
Phone 802.878.7232
Fax 802.878.8001

1/18/2002



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

To Whom It May Concern:

Enclosed you will find two completed references on Anne Hildreth, a PA affricated with Planned Parenthood of Northern New England. Please feel free to call me at (802) 878-7716 x 241, if you have any questions.

Sincerely,

Beverly Dion

Beverly Dion
Credentialing Coordinator

Enclosure

Printed on Recycled Paper

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

Office Location:
One Prospect Street
Montpelier, VT 05602

State of Vermont
Board of Medical Practice

TO: Cassie Silta

FROM: Jenny

DATE: 2-14-02

RE: Anne Hildreth PA

Number of pages including cover sheet: 3

Message: Cassie:

Here is the Scope for Ann. She is mailing me the Original with the Signatures. I hope you can do the interview with this copy. If not let me know.

Jenny

This fax contains confidential information and is intended solely for the person to whom it is addressed. If this fax has been sent to you in error, please forward to the appropriate person or notify this office immediately at the phone number indicated above. Thank you.

FROM: Bev Dion
183 Talcott Road, Suite 101
Williston, VT 05495
Phone: (802) 878-7232
Fax: (802) 878-8001

Date: 2/13/02

To: Jen

Phone:

Fax: (802) 828-5450

Number of pages (including cover page): 3

RE:

Scope of practice for Anne Hildreth:

thank you

STATEMENT OF CONFIDENTIALITY

facsimile transmittal sheet, and any document that may be transmitted with it, may contain information which is confidential or privileged and is intended solely for the use of the addressee. Any disclosure, photocopying, distribution, or other use of the nts of this faxed information is prohibited. If you receive this facsimile in error, please notify us by telephone immed ements will be made for retrieval of the original documents at no cost to you.

David A. Halsey, M.D.
David L. Muller, M.D.
Leonard M. Rudolf, M.D.
Katherine A. Silta PA-C
Sandeep B. Varma, M.D.

Connecticut Valley Orthopaedics & Sports Medicine, P.C.

ORTHOPAEDIC MEDICINE
- Occupational Injuries
- Arthritis Care
- Spine Care

ORTHOPAEDIC SURGERY
- Arthroscopy
- Arthroplasty
- Fracture Care
- Reconstructive Surgery

SPORTS MEDICINE CENTER
- Education
- Prevention
- Sports Injury Care
- Sport-Specific Training

FACSIMILE COVER SHEET

DATE: 2/14/02

NUMBER OF PAGES (INCLUDING COVER SHEET) 3

TO: Jenny Ansel
B.O.M.P.

FAX NUMBER: (802) 828-5450

FROM: SILTA

ATTENTION: This message is intended only for the individual to whom it is addressed. It contains information that may be confidential under law. If you are not the intended recipient or agent responsible for delivering this message, do not read, copy or distribute this information. If you have received this message in error, please notify us immediately by phone and return the message to us by mail. Thank You.

Springfield, VT Office • Box 2003 • 29 Ridgewood Road • Springfield, Vermont 05156 • 802-885-4373 • Fax 802-885-8376
Claremont, NH Office • 241 Elm Street • Claremont, New Hampshire 03743 • 603-542-5801 • Fax 603-542-5831
Lebanon, NH Office • 129C Mascoma Street • Lebanon, New Hampshire 03766 • 603-448-6344 • Fax 603-448-3405

PHYSICIAN'S ASSISTANT SCOPE OF PRACTICE
at Planned Parenthood of Northern New England

Planned Parenthood of Northern New England's Scope of Practice for Physician's Assistants consists of several documents:

1) PPNNE Standing Orders: Each P.A. practitioner annually signs the Standing Orders that are approved by PPNNE's Medical Advisory Committee then co-signed by PPNNE's Medical Director. Standing Orders define the prescriptive and medical authority of the P.A. practitioner at PPNNE.

2) PPNNE's Medical Protocol: The exact duties of the P.A. are clearly defined in PPNNE's Medical Protocol, a copy of which is on file with the Vermont Board of Medical Practice.

3) Medical Oversight at PPNNE. Please refer to the attached document, Medical Oversight at PPNNE, for information about the structure of supervision of P.A.'s at PPNNE.

4) Additional information about PPNNE's health centers, patient population and P.A. practice at Planned Parenthood of Northern New England:

Planned Parenthood of Northern New England is a non-profit health care organization with fifteen outpatient health centers in Vermont. Under the supervision of PPNNE's Medical Director, Physician's Assistants at PPNNE health centers provide outpatient gynelogical and preventive care for women and men as outlined in PPNNE's Standing Orders and Medical Protocols.

Many of our sites are located in rural areas where access to health care may be difficult. PPNNE offers a sliding fee scale based on the individual's ability to pay. Our commitment to providing services regardless of a client's ability to pay means that thousands of Vermonters without health insurance have access to high quality reproductive and preventive health care.

While the majority of our clients are between the ages of 20 and 34, 27% of our patients are teenagers and 15% are over 35 years old. In addition, many of our clients are economically disadvantaged.

As specified in Section I, Part I of the PPNNE Medical Protocol, each clinic site is

see p. 2

required to inform patients how to obtain care in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinic as well as the medical back-up arrangements with a physician or hospital.

PFNNP's P.A. Practitioners do not independently prescribe or dispense controlled substances and therefore, do not have DEA numbers.

Terry -
This does not conform to our format as set out in the rules ie: narrative, site, supervision, etc.
Also it is not signed by the PA or supervising MD.
They keep referring to a protocol (Item #2) Do we even have it?
Case

Kas

✓ #1890 $2000

Planned Parenthood®
of Northern New England

SERVING MAINE, NEW HAMPSHIRE AND VERMONT

241 Elm Street
Claremont, NH
03743
603.542.4568

RECEIVED
JAN 08 2002
NH BOARD OF MEDICINE
RECEIVED
JAN 2002
NH BOARD OF MEDICINE
NH BOARD OF MEDICINE

1/08/02

Please send verification of my current license in the STATE of N.H. to the VT. Board of medicine — Thank you!

Sincerely -
Anne Hildreth PA-C
License# 0084

WEEKLY COMPUTER PRINTOUT STATUS OF BILLS

☐ **11.** FIRST CLASS MAIL $225.00

☐ **12.** THIRD CLASS MAIL $115.00

☐ **13.** PICKED UP AT DOCUMENT ROOM $60.00

☐ **20.** ***WEEKLY LEGISLATIVE CALENDAR***
FIRST CLASS MAIL $25.00

☐ **21.** ***ROLL CALL VOTES (House & Senate)***
FIRST CLASS MAIL-weekly $75.00

☐ **22.** PICKED UP AT DOCUMENT ROOM $25.00

Mail this order form along with full payment to:
Joseph W. Mayo, Clerk of the House
2 State House Station
Augusta, Maine 04333-0002

Checks should be made payable to Treasurer, State of Maine.

IF YOU HAVE ANY QUESTIONS REGARDING DOCUMENT SERVICE PLEASE CALL CHRIS WORMELL AT (207) 287-1400.

MAILING ADDRESS (Please print name of person or company receiving documents) NEW ENGLAND OF NORTERN

NAME: KIM CRICHTON ***COMPANY:*** PLANNED PARENTHOOD

ADDRESS: 367 US ROUTE ONE
(STREET)

FALMOUTH, ME 04105 781-2201.
(CITY) ***(STATE)*** ***(ZIP CODE)*** ***(TEL. NO.)***

NAME OF PERSON SUBMITTING ORDER IF DIFFERENT FROM ABOVE

Name: _____ ***Tel. No.*** _____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE

2004-2006 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION

I hereby apply for the **RENEWAL** of my **CERTIFICATION AS A PHYSICIAN ASSISTANT** for the period from 02/01/04 to 01/31/06.

****

TWO YEAR RENEWAL FEE: $75.00 for first certification; $50.00 for each additional certification
Please enclose a check in the proper amount made payable to the Vermont Board of Medical Practice.

Note: Physician Assistants 80 years of age or older are exempt from payment of a renewal fee; however, the Physician Assistant certification renewal application must still be completed and submitted.

Important:

- Please print legibly or type.
- Answer all questions completely -- it is not adequate to state that the Board already has the information. Use Form A to provide explanations to "yes" answers in Parts II and III.
- When space is insufficient, attach additional sheets.
- Make a copy of this form and all attachments for your own records.
- Do not delegate this important task, as false statements on this form are grounds for findings of unprofessional conduct.
- Be sure to complete the Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions.
- Please return the document in its entirely at your earliest convenience. Your current certificate expires on January 30, 2004.

RECEIVED
JAN 28 2004
VERMONT BOARD OF MEDICAL PRACTICE

PART I

1. Name: Anne Sarver Hildreth

2. Gender: ☐ Male ☒ Female

3. Vermont Certification Number: 055-0030584

4. Other Name(s), if any, under which you were certified or licensed in Vermont and elsewhere: _____

5. Home Address: [redacted]

City, State, Zip C[redacted]

6. Work Address: [redacted] 89 S. MAIN ST
W. LEBANON, NH 03784

Please check your preferred mailing address: ☐ Home ☒ Work
(This address will be public and listed on the Board's website)

7. Email Address [redacted]

8. Daytime Telephone Number: Area Code: (603) 298.7766

9. Date of Birth (Month/Day/Year): [redacted]

10. Place of Birth: [redacted]

11. Certification Examination Taken – (Check box and enter date of examination):

- ☒ (__/__/__) NCCAA 96 yrs.
- ☐ (__/__/__) State Examination-Identity by state:_____
- ☐ (__/__/__) Other Examination specify: _____

12. Basis for Vermont Certification – (Check box):

- ☐ Apprenticeship Trained
- ☒ University Trained

13. Do you have hospital privileges in Vermont? ☐ Yes ☒ No

Hospital Name(s) and Location(s): _____

14. In what year did you start working as a physician assistant in Vermont? ~~[illegible]~~ 2003

15. Did you practice in Vermont during the past 12 months? ☒ Yes ☐ No

An applicant for certification renewal who has not practiced as a Physician Assistant for more than twelve months must submit a satisfactory evaluation by the Supervising Physician.

16. Other states where you now hold an active certification or license to practice: N.H.

17. States where you previously were certified or licensed to practice: Mass.

18. Specialty: OB/GYN DEA Number: MH0195986

19. Name and office address of current **EMPLOYER**:

Name	Address
PPNNE	895. MAIN ST, W. Lebanon, NH
	241 Elm ST. Claremont, NH.

20. Please indicate the total number and list (use additional sheet if necessary) name(s) and address(es) of physicians who currently serve as your **PRIMARY and SECONDARY SUPERVISING PHYSICIAN(S).**

Total number 3

Primary Supervising Physician(s):

Name: Cheryl A. Gibson
Address:
23 Mansfield Avenue
Burlington, VT 5401

Name	Address

Secondary Supervising Physician(s):

Name	Address
Susan Smith	23 Mansfield Ave, Burl. VT. 05401
Kym Boyman	

21. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current scope of practice for your practice setting, paying attention to any additions or deletions in duties and procedures. Please review, date and sign your scope of practice and have your **PRIMARY SUPERVISING PHYSICIAN** sign it as well. Attach a copy of your signed scope of practice to this application.

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

22. Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a Physician Assistant within the past twelve months.

23. **Continuing Medical Education (CME) requirements:**

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

    b. For all others, an explanation of requirements and a logging form must be completed.

24. Primary Supervising Physician and Second Supervisory Physician forms are provided. They must be completed and returned with this application.

PART II

"Yes" answers to Questions 25 - 39 require an explanation on 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, please indicate that on Form A.

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

Certification and Practice Questions

25. Have you ever applied for and been denied a license or certificate to practice medicine or any other healing art? ☐ Yes ☒ No
26. Have you ever withdrawn an application for a license or certificate to practice medicine or any other healing art? ☐ Yes ☒ No
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? ☐ Yes ☒ No
28. 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
29. Have you ever been denied the privilege of taking an examination before any state medical examining board? ☐ Yes ☒ No
30. Have you ever discontinued your education, training, or practice for a period of more than three months, for reasons other than a family situation? ☐ Yes ☒ No
31. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion? ☐ Yes ☒ No

32. 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

33. 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

34. Are you presently a defendant in a criminal proceeding? ☐ Yes ☒ No

PART III

Confidential Section (This section is exempt from public disclosure)
Any "yes" response to the questions below must be fully explained on Form A.

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

36. 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" – This term 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 certified professional.

"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.

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

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

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

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

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

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

IMPORTANT

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

Part IV - Statutory Profile Questions

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 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 or certification authority decisions, and other documents relevant to the questions below in order to have a true and accurate description of the actions taken.

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

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past 10 years. For purposes of this question, "convicted" means that you pleaded guilty or that you were found or adjudged guilty by a court of competent jurisdiction. **Please provide copies of papers fully documenting the convictions.**

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

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

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction. **Please provide copies of papers fully documenting these matters.**

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

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

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

(Date)	(Final Disposition - Summary)
(Date)	(Final Disposition - Summary)
(Date)	(Final Disposition - Summary)

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

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

A. Revocation/Involuntary Restrictions

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

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

B. Other Restrictions

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. **Please provide copies of papers fully documenting these matters.**

(Date) (Hospital) (State)

(Nature of Action) (Action)

(Reason for Action) ☐ In lieu ☐ In settlement

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

A. Judgments

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**

☐ Judgement ☐ Arbitration

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

☐ Judgement ☐ Arbitration

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

B. Settlements

Please provide a description of all settlements of medical malpractice claims against you in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**

(Date) (Court) (State) (Amount of Settlement Against You)

(Date) (Court) (State) (Amount of Settlement Against You)

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

What month and year did you start practicing as a Physician's Assistant? 6/1984

47. Appointments/Teaching [See 26 VSA § 1368(a)(12)] Note: Answering #35 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

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

Dartmouth MS Hanover NH Adjunct Faculty 2000 → present

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

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

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)

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

Note: Answering #51 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)

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

Note: Answering #52 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)

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

What is the location of your primary practice setting?

Town/City, State

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

Please identify any translating services available at your primary practice location.

Are any translating services available at your primary practice location? ☐ Yes ☐ No

If yes, please describe the translating services available:

_____

_____

_____

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

A. Medicaid participation
Do you participate in the Medicaid program? ☒ Yes ☐ No

B. New Medicaid Patients
Are you currently accepting new Medicaid patients? ☒ Yes ☐ No

Part V

Are you currently active in clinical practice in Vermont? ☐ Yes ☒ No (trainings)

If you do not provide patient care in Vermont, skip the rest of Part V and go to Part VI.

For the practice location(s) in Vermont related to this certificate, please answer the questions below.

Please select the specialty codes from the list provided (link), and enter the average hours per week you spend providing DIRECT PATIENT CARE. Include both AMBULATORY care and HOSPITAL care of patients who originate from this site. Please exclude on-call hours.

Enter the Vermont town name for this location: _____

Select the ONE practice setting that best describes this practice:
(If you provide hospital care to patients who originate from your office or clinic, choose only the setting from which they originate.)

☐ Community-Based practice (including associated hospital care - solo or group office, Community Health Center, etc.)
☐ Hospital-based practice (Inpatient, Emergency Room, etc)
☐ School or College Health Center
☐ Business or Work Site
☐ Extended Care / Nursing Home
☐ Other: _____

I work as a locum tenens here ☐Yes ☐No

If this is an office-based practice, please answer the following:

I currently have patients here covered by Medicaid ☐Yes ☐No
I currently have patients here covered by Medicare ☐Yes ☐No
I will accept new patients here ☐Yes ☐No
I will accept new Medicaid patients here ☐Yes ☐No
I will accept new Medicare patients here ☐Yes ☐No

Enter the number of weeks you spend providing direct patient care here in a year:
(48 weeks is considered to be "full time") ___ [2 digits]

Enter your specialty and the number of hours you spend providing direct patient care here under that specialty in an average work week:

First Specialty: _____ [4 digits] (see attached list or link) Hours per week: ____ [2 digits]

Second Specialty: _____ [4 digits] (see attached list or link) Hours per week: ____ [2 digits]

Do you plan to retire or reduce your patient care hours AT THIS SITE in the next 12 months? ☐Yes ☐No

If you work at another location or setting UNDER THE SAME CERTIFICATE please answer the questions below. If you work only at one site under this certificate please stop here, leave Part V blank, and skip to Part VI. (If you work at another site under a different certificate, please describe your work at that site in the renewal form for that other certificate, not here.)

Enter the Vermont town name for the second location: _____

Select the ONE practice setting that best describes this practice:
(If you provide hospital care to patients who originate from your office or clinic, choose only the setting from which they originate.)

- ☐ Community-Based practice (including associated hospital care - solo or group office, Community Health Center, etc.)
- ☐ Hospital-based practice (Inpatient, Emergency Room, etc)
- ☐ School or College Health Center
- ☐ Business or Work Site
- ☐ Extended Care / Nursing Home
- ☐ Other:_____

I work as a locum tenens here ☐Yes ☐No

If this is an office-based practice, please answer the following:

I currently have patients here covered by Medicaid	☐Yes ☐No
I currently have patients here covered by Medicare	☐Yes ☐No
I will accept new patients here	☐Yes ☐No
I will accept new Medicaid patients here	☐Yes ☐No
I will accept new Medicare patients here	☐Yes ☐No

Enter the number of weeks you spend providing direct patient care here in a year:
(48 weeks is considered to be "full time") ____ [2 digits]

Enter your specialty and the number of hours you spend providing direct patient care here under that specialty in an average work week:

First Specialty: _____ [4 digits] (see attached list or link) Hours per week: ____ [2 digits]

Second Specialty: _____ [4 digits] (see attached list or link) Hours per week: ____ [2 digits]

Do you plan to retire or reduce your patient care hours AT THIS SITE in the next 12 months? ☐Yes ☐No

If you work at more than two locations UNDER THE SAME CERTIFICATE please describe the additional site(s) briefly, e.g., "same specialty and hours in additional towns: X and Y":

_____

_____

Part VI

Reminder - You must also complete the Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions

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

Date: 12/10/03

Applicant's Signature

Vermont Department of Health
Board of Medical Practice
P.O. Box 70, Burlington, VT 05402

532-34-1978

January 13, 2004

Vermont Board of Nursing
109 State Street
Montpelier, Vermont 05609-1106

To Whom It May Concern:

This is to verify that for the last twelve months, Anne Hildreth has practiced as a Physician's Assistant at Planned Parenthood of Northern New England.

Please feel free to direct any questions you may have to our Credentialing Coordinator, Beverly Dion, at (802) 878-7232.

Sincerely,

Cheryl Gibson
Medical Director

The National Commission on Certification
of Physician Assistants
affirms that

Anne Sarver Hildreth

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

President

Certificate Number: 1011311
Expiration Date: December 31, 2005

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

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Gibson (Last) Cheryl (First) A (Middle)

Mailing Address Planned Parenthood (Office Name)
23 Mansfield Ave. (Street)
Burl, VT. 05401 (City/State) (Zip Code) 863-6326 (Telephone Number)

Vermont License #: 042-0007465

Hospital(s) where you have privileges: FAHC Hospital(s) Location Burlington, VT. Specialty OB/GYN

What arrangements have you made for supervision when you are not available or out of town:
24/7 on call service
Two Back up secondary supervising Physicians

CERTIFICATE OF SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Anne Hildreth, P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician's assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.

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

1/15/04 (Date)

X [signature] (Signature of Supervising Physician)

Co-signature of PA: [signature]

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MH0195986

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Smith (Last) Susan (First) — (Middle)

Mailing Address Planned Parenthood (Office Name)
23 Mansfield Ave. (Street)
Burl, VT. 05401 (City/State) (Zip Code) 863-6326 (Telephone Number)

Vermont License #: 042-0005990

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
F.A.H.C	Burlington, VT.	OB/GYN.

List all physician's assistants names and addresses you currently supervise:
Amy Borgman - P.P BARRE Johanna Hauser - P.P Burlington Barb Nolfi - PP Burl.
August Burns - P.P Hyde Park Katra Kindar - P.P Burlington Janet Young - P.P Burl.
Sue Burton - P.P Burlington Cate Nicholas - P.P Burlington Anne Hildreth P.P Springfield

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

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

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

1/22/04 (Date)

X S Smith (Signature of Secondary Supervising Physician)

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Boyman (Last) Kym (First) M. (Middle)

Mailing Address Planned Parenthood (Office Name)
23 Mansfield Ave. (Street)
Burlington, VT. 05401 (City/State) (Zip Code) 863-6326 (Telephone Number)

Vermont License #: 042-0010597

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
F.A.H.C	Burlington, VT.	OB/GYN.

List all physician's assistants names and addresses you currently supervise:
Amy Borgman - P.P BARRE Johanna Hauser - P.P Burlington Barb Nati - P.P Burl.
August Burns - P.P Hyde Park Katra Kindar - P.P Burlington Janet Yang - P.P Burl.
Sue Burton - P.P Burlington Cate Nicholas - P.P Burlington Anne Hildreth - Springfield

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

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

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

1/22/04 (Date)

X (Signature of Secondary Supervising Physician)

PHYSICIAN'S ASSISTANT SCOPE OF PRACTICE
at Planned Parenthood of Northern New England

Planned Parenthood of Northern New England's Scope of Practice for Physician's Assistants consists of several documents:

1) PPNNE Standing Orders: Each P.A. practitioner annually signs the Standing Orders that are approved by PPNNE's Medical Advisory Committee then co-signed by PPNNE's Medical Director. Standing Orders define the prescriptive and medical authority of the P.A. practitioner at PPNNE.

2) PPNNE's Medical Protocol: The exact duties of the P.A. are clearly defined in PPNNE's Medical Protocol, a copy of which is on file with the Vermont Board of Medical Practice.

3) Medical Oversight at PPNNE: Please refer to the attached document, Medical Oversight at PPNNE, for information about the structure of supervision of P.A.'s at PPNNE.

4) Additional information about PPNNE's health centers, patient population and P.A. practice at Planned Parenthood of Northern New England:

Planned Parenthood of Northern New England is a non-profit health care organization with fifteen outpatient health centers in Vermont. Under the supervision of PPNNE's Medical Director, Physician's Assistants at PPNNE health centers provide outpatient gynelogical and preventive care for women and men as outlined in PPNNE's Standing Orders and Medical Protocols.

Many of our sites are located in rural areas where access to health care may be difficult. PPNNE offers a sliding fee scale based on the individual's ability to pay. Our commitment to providing services regardless of a client's ability to pay means that thousands of Vermonters without health insurance have access to high quality reproductive and preventive health care.

While the majority of our clients are between the ages of 20 and 34, 27% of our patients are teenagers, and 15% are over 35 years old. In addition, many of our clients are economically disadvantaged.

As specified in Section I, Part I of the PPNNE Medical Protocol, each clinic site is

Vermont Department of Health - Board of Medical Practice

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

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

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

or

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

Regarding Taxes

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

2. You must check one of the two statements below regarding taxes:

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

or

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

Regarding Unemployment Compensation Contributions

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

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

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

or

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant [signature] Date 1/29/04

ANNE HILDRETH

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

PC 75.00
25.00

2006 PHYSICIAN ASSISTANT CERTIFICATION RENEWAL APPLICATION

PART I

Certificate # 055-0030584

1. Name: Anne Sarver Hildreth PA-C

2. Other Name(s), if any, under which you were certified or licensed in Vermont and elsewhere:

_____

3. Home Address:

[redacted]

4. Work Address: 895 S. MAIN ST, PPDOE / PPDOE PO BOX 717

City, State, Zip Code: W. Lebanon, NH 03784 / Springfield, VT.

Please check your preferred mailing address: ☒ Home ☐ Work
(This address will be public and listed on the Board's website)

5. Email Address [redacted]

6. Daytime Telephone Number: Area Code: (603) 340-1566

7. Date of Birth: Month:

[redacted]

8. Place of Birth: [redacted]

9. Certification Examination Taken – (Check box and enter date of examination):

JAN 5 2006

☐ (___/___/___) NCCPA

☐ (___/___/___) State Examination-Identify state:_____

☐ (___/___/___) Other Examination specify: NCCPA

10. Basis for Vermont Certification – (Check box):

☐ Apprenticeship Trained
☒ University Trained

11. Do you have hospital privileges in Vermont? ☐ Yes ☒ No

Hospital Name(s) and Location(s):

_____
_____
_____
_____

12. In what year did you start working as a physician assistant in Vermont? _____

12. In what year did you start working as a physician assistant in Vermont? 1986

13. Did you practice in Vermont during the past 12 months? ☑ Yes ☐ No

14. Other states where you now hold an active certification or license to practice:

none

15. States where you previously were certified or licensed to practice:

Washington, D.C. and Annadale, VA.

16. Specialty: GYN. DEA Number: MB0763234

17. Name and office address of current EMPLOYER:

Name	Address
Planned Parenthood	90 Washington St. Barre, VT. 05641

18. Please list (use additional sheet if necessary) name(s) and address(es) of physicians who currently serve as your PRIMARY and SECONDARY SUPERVISING PHYSICIAN(S).

Primary Supervising Physician(s):

Name	Address
Cheryl Gibson	23 Mansfield Ave. Burl, VT. 05401

Secondary Supervising Physician(s):

Name	Address
Susan Smith	23 Mansfield Ave. Burl, VT. 05401

19. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current scope of practice for your practice setting, paying attention to any additions or deletions in duties and procedures. Please review, date and sign your scope of practice and have your PRIMARY SUPERVISING PHYSICIAN sign it as well. Attach a copy of your signed scope of practice to this application.

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

20. Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a Physician Assistant within the past twelve months.

21. Continuing Medical Education (CME) requirements:

    a. NCCPA certified Physician Assistant: Attach proof of current NCCPA certification; this will serve as

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

PART III

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IMPORTANT

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

Part IV - Statutory Profile Questions

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

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 38 through 43 have changed since your last application. We cannot process your application without them.

38. Criminal Convictions [See 26 VSA § 1368(a)(1)] ☒ Check here if none

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past 10 years **Please provide complete copies of documentation for each matter.**

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

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

Part IV - Statutory Profile Questions

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

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 38 through 43 have changed since your last application. We cannot process your application without them.

38. Criminal Convictions [See 26 VSA § 1368(a)(1)] ☐ Check here if none

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past 10 years **Please provide complete copies of documentation for each matter.**

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

39. Nolo Contendere/Matters Continued [See 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. **Please provide complete copies of documentation for each matter.**

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

40. Vermont Board of Medical Practice Matters [See 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.

(Date)	(Final Disposition - Summary)
(Date)	(Final Disposition - Summary)
(Date)	(Final Disposition - Summary)

41. Licensing or Certification Authority Matters in Other States [See 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. **Please provide complete copies of documentation for each matter.**

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

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

42. Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)] ☑ Check here if none

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 complete copies of documentation for each matter.**

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

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

B. Other Restrictions ☑ Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. **Please provide complete copies of documentation for each matter.**

_____
(Date) (Hospital) (State)

_____
(Nature of Action) (Action)
_____ ☐ In lieu ☐ In settlement
(Reason for Action)

43. Medical Malpractice Court Judgments/Settlements [See 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.**

☐ Judgment ☐ Arbitration

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

☐ Judgment ☐ Arbitration

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

B. Settlements ☑ Check here 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.**

(Date) (Court) (State) (Amount of Settlement Against You)

(Date) (Court) (State) (Amount of Settlement Against You)

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

What month and year did you start practicing as a Physician Assistant? August, 1983

45. Appointments/Teaching [See 26 VSA § 1368(a)(12)] Note: Answering #48 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

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

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

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

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)

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

Note: Answering #49 is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

_____
(Title) (Publication) (Year)

_____
(Title) (Publication) (Year)

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

Note: Answering #50 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)

_____

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

What is the location of your primary practice setting?
Barre, VT. (90 Washington St.) Planned Parenthood
Town/City, State

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

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location? ☐ Yes ☑ No

If yes, please describe the translating services available:

_____

_____

_____

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

A. Medicaid participation
Do you participate in the Medicaid program? ☒ Yes ☐ No

B. New Medicaid Patients
Are you currently accepting new Medicaid patients? ☒ Yes ☐ No

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 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 12/8/05

National Commission on Certification of Physician Assistants

hereby affirms that

Anne Sarver Hildreth

has successfully completed all certification requirements and earned the right to use the

Physician Assistant-Certified

designation.

Certificate Number: 1011311

Effective On: November 4, 2005

Expires On: December 31, 2007

Dorothy D. Pearson, PA-C, Chairman of the Board

Janet J. Lathrop, President

Randy D. Danielsen, PhD, PA-C, Secretary

This certificate is property of NCCPA and must be returned upon request. This certificate does not constitute proof of certification. For valid proof of certification, contact NCCPA.

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Gibson (Last) Cheryl (First) A (Middle)

Mailing Address Planned Parenthood (Office Name)
183 Talcott RD. (Street)
Williston, VT. (City/State) 05495 (Zip Code) (802) 878-7232 (Telephone Number)

Vermont License #: 042-0007465

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Fletcher Allen Health Care	Burlington	OB/GYN

What arrangements have you made for supervision when you are not available or out of town:

Coverage by another physician

CERTIFICATE OF SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Anne Hildreth, P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.

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

12/15/05 (Date) (Signature of Supervising Physician)

Co-signature of PA: Anne Hildreth PA

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MH0195986

LPA # 055-0030584

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Smith (Last) Susan (First) P (Middle)

Mailing Address Planned Parenthood (Office Name)

183 Talcott RD. (Street)

Williston, VT. (City/State) 05495 (Zip Code) (802) 878-7232 (Telephone Number)

Vermont License #: 042-0005990

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Fletcher Allen Health care	Burlington	OB/GYN

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

Amy Borgman - Barre, VT.
August Burns - Hyde Park, VT.
Johanna Hauser - Williston, VT.
Catherine Nicholas - Burlington, VT.
Katra Kinda - Burl., VT.
Janet Young - Burl, VT.
Anne Hildreth - BARRE, VT.

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

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

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

12/18/05 (Date)

X Susan Smith (Signature of Secondary Supervising Physician)

PA # 055-0030584

Planned Parenthood®
of Northern New England

SERVING MAINE, NEW HAMPSHIRE AND VERMONT

CENTRAL OFFICE
183 Talcott Road, Suite 101
Williston, VT
05495
Phone 802.878.7232
Fax 802.878.8001

December 15, 2005

State of Vermont-Board of Medical Practice
108 Cherry Street
Burlington, VT 05401

To Whom It May Concern:

This is to certify that the Physician's Assistant named below has practiced under my supervision, in Vermont, within the last twelve months:

- Anne Hildreth PA # 055-0030584

In addition, the Physician's Assistant named above maintains a Drug Enforcement Agency certification, and will be authorized to prescribe medications in accordance with Planned Parenthood's Scope of Practice, which has been submitted to and approved by the Vermont Board of Medical Practice.

Sincerely,

Cheryl Gibson
Medical Director

Printed on Recycled Paper

Planned Parenthood
of Northern New England

Standing Orders for
Nurse Practitioners, Certified Nurse Midwifes & Physician Assistants

The Family Planning Practitioner may:

A. Provide information and counseling on: family planning methods; sterilization; pregnancy; adoption; abortion; common gynecological problems; sexually transmitted diseases; sexual assault; male reproductive health; infertility; maternity care; midlife health; well child care; general preventive health care.

B. 1) Order and dispense hormonal contraceptives and HRT in accordance with the PPNNE Medical Protocol.
2) Manage routine hormonal contraceptive and HRT problems.
3) Order special laboratory tests needed to prescribe hormonal contraceptives and HRT.

C. 1) Insert and remove the Norplant contraceptive system in accordance with the PPNNE Medical Protocol.
2) Manage routine Norplant problems.

D. 1) Inject Medroxyprogesterone acetate (Depo-provera) in accordance with PPNNE Medical Protocol.
2) Manage routine DMPA problems.

E. 1) Insert and remove IUD's in accordance with the PPNNE Medical Protocol.
2) Manage routine IUD problems.
3) Order X-rays and sonograms for IUD localization.

F. 1) Fit and check diaphragms and cervical caps in accordance with the PPNNE Medical Protocol.
2) Manage diaphragm and cervical cap problems.

G. 1) Order and dispense condoms and vaginal spermicides in accordance with the PPNNE Medical Protocol.
2) Manage condom and spermicide problems.

H. Counsel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervic mucus and calendar.

I. Evaluate patient history, perform elementary physical examination and pelvic examination, order and evaluate laboratory an other tests as indicated and administer immunizations and other medications in accordance with the PPNNE Medical Protocol.

J. Order, administer and/or dispense medications in accordance with the PPNNE Medical Protocol and state and federal laws.

K. Diagnose and order or dispense treatment for conditions covered in the PPNNE Medical Protocol as indicated in the protoc

L. Perform pregnancy diagnosis as per the PPNNE Medical Protocol. Order serum HCG pregnancy test, titers and sonograms

M. Provide services to patients in the maternity care, abortion, vasectomy, cervical dysplasia, infertility, male services, well chil and midlife programs as per the PPNNE Medical Protocol and Medical Protocol Supplements.

N. Provide routine gynecologic and general preventive health care as per the PPNNE Medical Protocol. Manage and follow-up routine and problem patients in accordance with the PPNNE Medical Protocol.

O. Perform venipuncture; start and maintain I.V.'s.

P. Order and follow-up on outside laboratory tests and dispense treatment for conditions not specifically covered in the PPNNE Medical Protocol under the direct guidance of a PPNNE physician with the Medical Director's approval.

Q. Pursuant to delegation from the Medical Director, to provide reproductive health care to minors, including and especially contraception and diagnosis and treatment of sexually transmitted infections, as indicated with or without parent consent if the minor may suffer probable health hazards if such services are not provided.

The Family Planning Practitioner must:

A. Adhere to the PPNNE Medical Protocol.
B. Obtain physician consultation in all non-routine clinical matters.
C. Follow-up and report all complications and all potential medico-legal incidents to the Medical Director.

I agree to practice under the above standing orders

Anne Hildreth (PA # 055-0030594)
Print Name

Anne Hildreth 3/18/05
Signature Date

Collaborating Physician: Cheryl Gibson, MD, Medical Dire

PPNNE Form 10HR 9/21/04es

(3/18/05)

Anne Hildreth PA# 055-0030584

Medical Oversight at Planned Parenthood of Northern New England

Physician Oversight

All PPNNE practitioners undergo a thorough orientation to PPNNE and our medical protocol before functioning in an independent capacity. If further training in any expected area of competence is needed, this is arranged.

The Medical Director, a board certified OB/GYN., provides oversight and supervision through on-site visits and consultations, telephone consultations and quarterly in-services. She is available for telephone back up on a 24-hour basis. In addition, the Medical Director works with the Medical Management Team and the Director of Clinical Quality Improvement to develop and review protocols, audits, and to evaluate any new developments in the medical field that may affect PPNNE. All PPNNE mid-level practitioners practice under Standing Orders developed by the Medical Director. Practitioners attend quarterly continuing education in-service for medical training, discussion of protocol questions and other practice concerns. They also attend outside CME conferences. In addition, we have community Physicians who are available to our staff for consultation, telephone back up and review of charts.

Practice Protocols

Our medical protocol is based on standards set by Planned Parenthood Federation of America, and the U.S. Department of Health and Human Services. Comprised of nationally recognized experts in specialties and sub-specialties of reproductive healthcare, the National Medical Committee establishes standards and guidelines that all Planned Parenthood Federation of America affiliates must follow. This committee provides us with updates and revisions to the PPFA standards and guidelines on an on-going basis. These are incorporated into PPNNE'S protocol.

Medical Management Team

This team meets quarterly to discuss various medical management issues and to determine appropriate resolution of these issues under the Medical Director's guidance and final approval.

Director of Clinical Quality Improvement

The Director of Clinical Quality Improvement develops, oversees and conducts on-going audits of our medical programs.

1. Quality Assurance Site Audit:
   The Director of Clinical Quality Improvement conducts an extensive annual on-site evaluation of each clinic. The audit includes a comprehensive review of charts, laboratory and pharmacy logs and practitioner performance, as well as an evaluation of the safety of the clinic.

2. Medical Record and Patient Care Audits:
   Medical Record and Patient Care Audits are conducted three times each year. The specific topics are selected by the Director of Quality Assurance in close consultation with the Medical Management Team. Some examples of audit topics include: follow-up of abnormal pap smears, documentation of informed consent, and tracking of lot numbers for any medications in the event of a recall.

Results of all these audits are shared with all medical staff. Corrective measures are taken when indicated, and re-audits conducted when sites are found to be out of compliance.

Ann Hildreth PA# 055-0030584

PHYSICIAN'S ASSISTANT SCOPE OF PRACTICE
at Planned Parenthood of Northern New England

Planned Parenthood of Northern New England's Scope of Practice for Physician's Assistants consists of several documents:

1) PPNNE Standing Orders: Each P.A. practitioner annually signs the Standing Orders that are approved by PPNNE's Medical Advisory Committee then co-signed by PPNNE's Medical Director. Standing Orders define the prescriptive and medical authority of the P.A. practitioner at PPNNE.

2) PPNNE's Medical Protocol: The exact duties of the P.A. are clearly defined in PPNNE's Medical Protocol, a copy of which is on file with the Vermont Board of Medical Practice.

3) Medical Oversight at PPNNE: Please refer to the attached document, Medical Oversight at PPNNE, for information about the structure of supervision of P.A.'s at PPNNE.

4) Additional information about PPNNE's health centers, patient population and P.A. practice at Planned Parenthood of Northern New England:

   Planned Parenthood of Northern New England is a non-profit health care organization with fifteen outpatient health centers in Vermont. Under the supervision of PPNNE's Medical Director, Physician's Assistants at PPNNE health centers provide outpatient gynelogical and preventive care for women and men as outlined in PPNNE's Standing Orders and Medical Protocols.

   Many of our sites are located in rural areas where access to health care may be difficult. PPNNE offers a sliding fee scale based on the individual's ability to pay. Our commitment to providing services regardless of a client's ability to pay means that thousands of Vermonters without health insurance have access to high quality reproductive and preventive health care.

   While the majority of our clients are between the ages of 20 and 34, 27% of our patients are teenagers, and 15% are over 35 years old. In addition, many of our clients are economically disadvantaged.

   As specified in Section I, Part I of the PPNNE Medical Protocol, each clinic site is required to inform patients how to obtain care in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinic as well as the medical back-up arrangements with a physician or hospital.

Pd 4/15

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 ASSISTANT CERTIFICATION RENEWAL APPLICATION

PART I

Certificate #055-0030584

1. Name: Anne Sarver Hildreth PA-C

2. Other Name(s), if any, under which you were certified or licensed in Vermont and elsewhere:

_____

3. Work Address: [redacted]

4. Home Address: PPNNE- 6 Roberts North

City, State, Zip Code: Rutland, VT. 05701

and. PPNNE 89 Samson St. Lebb, NH. 03784

Please check your preferred mailing address: ☒ Home ☐ Work
(This address will be public and listed on the Board's website)

5. Email Address [redacted]

6. Daytime Telephone Number: Area Code: [redacted]

7. Date of Birth: [redacted]

8. Place of Birth: [redacted]

RECEIVED
DEC 26 2007
Vermont Board of Medical Practice

9. Certification Examination Taken – (Check box and enter date of examination):

☒ (10/21/07) NCCPA

☐ (___/___/___) State Examination-Identify state:_____

☐ (___/___/___) Other Examination specify: _____

10. Basis for Vermont Certification – (Check box):

☐ Apprenticeship Trained
☒ University Trained

11. Do you have hospital privileges in Vermont? ☐ Yes ☒ No
Hospital Name(s) and Location(s):

12. In what year did you start working as a physician assistant in Vermont? ~~1989~~ 12/01/06

13. Did you practice in Vermont during the past 12 months? ☒ Yes ☐ No

14. Other states where you now hold an active certification or license to practice: N.H.

15. States where you previously were certified or licensed to practice: MA. / N.H.

16. Specialty: OB/GYN DEA Number: MH0195986

17. Name and office address of current EMPLOYER:

Name	Address
PPNNE	183 Talcott Rd, Williston, VT.

18. Please list (use additional sheet if necessary) name(s) and address(es) of physicians who currently serve as your PRIMARY and SECONDARY SUPERVISING PHYSICIAN(S).

Primary Supervising Physician(s):

Name	Address
Dr. Cheryl Gibson	183 Talcott Rd, Williston, VT

Secondary Supervising Physician(s):

Name	Address
Dr. Susan Smith	183 Talcott Rd, Williston, VT

19. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current scope of practice for your practice setting, paying attention to any additions or deletions in duties and procedures. Please review, date and sign your scope of practice and have your PRIMARY SUPERVISING PHYSICIAN sign it as well. Attach a copy of your signed scope of practice to this application.

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

20. Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a Physician Assistant within the past twelve months.

21. Continuing Medical Education (CME) requirements:

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

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

22. Primary Supervising Physician and Second Supervisory Physician forms are provided. They must be completed and returned with this application.

PART II

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

23. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?
□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

PART III

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part IV - Statutory Profile Questions

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

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 38 through 43 have changed since your last application. We cannot process your application without them.

38. Criminal Convictions [See 26 VSA § 1368(a)(1)] ☒ Check here if none

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past 10 years **Please provide complete copies of documentation for each matter.**

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

39. Nolo Contendere/Matters Continued [See 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. **Please provide complete copies of documentation for each matter.**

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

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

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

40. Vermont Board of Medical Practice Matters [See 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.

(Date) (Final Disposition - Summary)

(Date) (Final Disposition - Summary)

(Date) (Final Disposition - Summary)

41. Licensing or Certification Authority Matters in Other States [See 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. **Please provide complete copies of documentation for each matter.**

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

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

42. Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)] ☒ Check here if none

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 complete copies of documentation for each matter.**

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

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

B. Other Restrictions ☒ Check here if none DPC 113108

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. **Please provide complete copies of documentation for each matter.**

(Date) (Hospital) (State)

(Nature of Action) (Action)

☐ In lieu ☐ In settlement

(Reason for Action)

43. Medical Malpractice Court Judgments/Settlements [See 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.**

☐ Judgment ☐ Arbitration

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

☐ Judgment ☐ Arbitration

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

B. Settlements ☒ Check here 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.**

(Date) (Court) (State) (Amount of Settlement Against You)

(Date) (Court) (State) (Amount of Settlement Against You)

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

What month and year did you start practicing as a Physician Assistant? 6/1984

45. Appointments/Teaching [See 26 VSA § 1368(a)(12)] Note: Answering #45 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

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

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

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

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)

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

Note: Answering #46 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)

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

Note: Answering #47 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)

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

What is the location of your primary practice setting?

89 So. Main St. W. Lebanon, NH. 03784

Town/City, State

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

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location? ☐ Yes ☑ No

If yes, please describe the translating services available:

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

A. Medicaid participation
Do you participate in the Medicaid program? ☒ Yes ~~☐ No~~

B. New Medicaid Patients
Are you currently accepting new Medicaid patients? ☒ Yes ☐ No

Part V

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

Date: 11/18/07

Applicant's Signature

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

Vermont Department of Health - Board of Medical Practice

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

You must answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than 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 [signature] Date 11/18/07

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Gibson (Last) Cheryl (First) A (Middle)

Mailing Address Planned Parenthood (Office Name)

183 Talcott RD. (Street)

Williston, VT. (City/State) 05495 (Zip Code) 288-8432 (Telephone Number)

Vermont License #: 042-0007465

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Fletcher Allen Health Care	Burl, VT.	OB/Gyn

What arrangements have you made for supervision when you are not available or out of town:
24/7 on call service, backed up by two MD's.

CERTIFICATE OF SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Anne Hildreth, P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.

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

12/17/07 (Date)

X (Signature of Supervising Physician)

Co-signature of PA: Anne Hildreth

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MH0195986

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Smith (Last) Susan (First) — (Middle)

Mailing Address Planned Parenthood (Office Name)

183 Talcott RD. (Street)

Williston, VT. (City/State) 05495 (Zip Code) 288-8432 (Telephone Number)

Vermont License #: 042-0005990

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Fletcher Allen Healthcare	Burl, VT.	OB/Gyn

List all physician's assistants names and addresses you currently supervise:
Amy Borgman - 90 Washington St. Barre, VT.
August Burns - 213 East Main St. Hyde Park, VT.
Johanna Hauser - 183 Talcott RD. Williston, VT.

over →

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

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

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

12/19/07 (Date)

X Susan J Smith (Signature of Secondary Supervising Physician)

Planned Parenthood®
of Northern New England

SERVING MAINE, NEW HAMPSHIRE AND VERMONT

CENTRAL OFFICE

183 Talcott Road, Suite 101
Williston, VT
05495

Phone 802.878.7232
Fax 802.878.8001

December 14, 2007

State of Vermont-Board of Medical Practice
Attn: Tracy Hayes
108 Cherry Street
Burlington, VT 05401

Dear Ms. Hayes,

This letter is to certify that the Physician's Assistant named below has practiced under my supervision, in Vermont, within the last twelve months:

- Anne Hildreth

In addition, the Physician's Assistant named above maintains a Drug Enforcement Agency certification, and will be authorized to prescribe medications in accordance with Planned Parenthood's Scope of Practice, which has been submitted to and approved by the Vermont Board of Medical Practice.

Sincerely,

Cheryl Gibson, M.D

PHYSICIAN'S ASSISTANT SCOPE OF PRACTICE
at Planned Parenthood of Northern New England

Planned Parenthood of Northern New England's Scope of Practice for Physician's Assistants consists of several documents:

1) PPNNE Standing Orders: Each P.A. practitioner annually signs the Standing Orders that are approved by PPNNE's Medical Advisory Committee then co-signed by PPNNE's Medical Director. Standing Orders define the prescriptive and medical authority of the P.A. practitioner at PPNNE.

2) PPNNE's Medical Protocol: The exact duties of the P.A. are clearly defined in PPNNE's Medical Protocol, a copy of which is on file with the Vermont Board of Medical Practice.

3) Medical Oversight at PPNNE: Please refer to the attached document, Medical Oversight at PPNNE, for information about the structure of supervision of P.A.'s at PPNNE.

4) Additional information about PPNNE's health centers, patient population and P.A. practice at Planned Parenthood of Northern New England:

Planned Parenthood of Northern New England is a non-profit health care organization with fourteen outpatient health centers in Vermont. Under the supervision of PPNNE's Medical Director, Physician's Assistants at PPNNE health centers provide outpatient gynelogical and preventive care for women and men as outlined in PPNNE's Standing Orders and Medical Protocols.

Many of our sites are located in rural areas where access to health care may be difficult. PPNNE offers a sliding fee scale based on the individual's ability to pay. Our commitment to providing services regardless of a client's ability to pay means that thousands of Vermonters without health insurance have access to high quality reproductive and preventive health care.

As specified in Section I, Part I of the PPNNE Medical Protocol, each clinic site is required to inform patients how to obtain care in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinic as well as the medical back-up arrangements with a physician or hospital.

NCCPA
12000 Findley Road
Suite 200
Duluth, GA 30097
Tel: 678-417-8100 Fax: 678-417-8135
Web: www.nccpa.net E-mail: nccpa@nccpa.net

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

NCCPA
National Commission on Certification
of Physician Assistants

Anne Sarver Hildreth

has completed all requirements to achieve
the NCCPA certification.

12/31/2009

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 ASSISTANT CERTIFICATION RENEWAL APPLICATION

PART I

Certificate #055-0030584

1. Name: Anne Sarver Hildreth PA-C

2. Other Name(s), if any, under which you were certified or licensed in Vermont and elsewhere:

N/A

3. Work Address:

[redacted]

4. Home Address: [redacted]

City, State, Zip Code:

Please check your preferred mailing address: ☒ Home ☐ Work
(This address will be public and listed on the Board's website)

5. Email Address: [redacted]

6. Daytime Telephone Number: Area Code:

[redacted]

7. Date of Birth:

[redacted]

8. Place of Birth: [redacted]

RECEIVED
JAN - 8 2010

9. Certification Examination Taken – (Check box and enter date of examination):

☐ (___/___/0) NCCPA

☐ (___/___/___) State Examination-Identify state:_____

☐ (___/___/___) Other Examination specify: _____

10. Basis for Vermont Certification – (Check box):

☐ Apprenticeship Trained
☒ University Trained

11. Do you have hospital privileges in Vermont? ☐ Yes ☒ No
Hospital Name(s) and Location(s):

12. In what year did you start working as a physician assistant in Vermont? _____

13. Were you in active clinical practice in Vermont during the past 12 months? ☒ Yes ☐ No

14. Other states where you now hold an active certification or license to practice:
N.H.

15. States where you previously were certified or licensed to practice:
N.H., MA

16. Specialty: OB/Gyn DEA Number: MH0195986

17. Name and office address of current EMPLOYER:

Name	Address
PPNNE	

18. Please list (use additional sheet if necessary) name(s) and address(es) of physicians who currently serve as your PRIMARY and SECONDARY SUPERVISING PHYSICIAN(S).

Primary Supervising Physician(s):

Name	Address
Cheryl Gibson	23 Mansfield Ave. Burl, VT. 05401

Secondary Supervising Physician(s):

Name	Address
Susan Smith	23 Mansfield Ave. Burl, VT. 05401

19. Scope of Practice: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current scope of practice for your practice setting, paying attention to any additions or deletions in duties and procedures. Please review, date and sign your scope of practice and have your PRIMARY SUPERVISING PHYSICIAN sign it as well. Attach a copy of your signed scope of practice to this application.

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

20. Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a Physician Assistant within the past twelve months.

21. Continuing Medical Education (CME) requirements:

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

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

22. Primary Supervising Physician and Second Supervisory Physician forms are provided. They must be completed and returned with this application.

PART II

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

23. Have you ever applied for and been denied a certificate to practice medicine or any other healing art?
□ yes ■ no

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

□ yes ■ no

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

□ yes ■ no

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

□ yes ■ no

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

□ yes ■ no

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

□ yes ■ no

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

□ yes ■ no

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

□ yes ■ no

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

□ yes ■ no

32. 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

33. 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.

34. To your knowledge, are you the subject of an investigation by any other licensing board under which you have not been charged as of the date of this application? [redacted]

35. 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 36 through 38.

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

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

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

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

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

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

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

[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.

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

[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.

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

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

IMPORTANT

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

Part IV - Statutory Profile Questions

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

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 38 through 43 have changed since your last application. We cannot process your application without them.

39. Criminal Convictions [See 26 VSA § 1368(a)(1)] ☑ Check here if none

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past 10 years **Please provide complete copies of documentation for each matter.**

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

40. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)] ☑ 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. **Please provide complete copies of documentation for each matter.**

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

41. Vermont Board of Medical Practice Matters [See 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.

_____

(Date) (Final Disposition - Summary)

42. Licensing or Certification Authority Matters in Other States [See 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. **Please provide complete copies of documentation for each matter.**

_____

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

43. Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)] ☐ Check here if none

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 complete copies of documentation for each matter.**

_____

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

B. Other Restrictions ☐ Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. **Please provide complete copies of documentation for each matter.**

_____

(Date) (Hospital) (State)

_____

(Nature of Action) (Action)

_____ ☐ In lieu ☐ In settlement

(Reason for Action)

44. Medical Malpractice Court Judgments/Settlements [See 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 n/a

☐ Judgment ☐ Arbitration

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

☐ Judgment ☐ Arbitration

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

B. Settlements ☒ Check here 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

(Date) (Court) (State) (Amount of Settlement Against You)

(Date) (Court) (State) (Amount of Settlement Against You)

45. Years of Practice [See 26 VSA § 1368(a)(10)] **1984**

What month and year did you start practicing as a Physician Assistant? 6/1984

46. Appointments/Teaching [See 26 VSA § 1368(a)(12)] Note: Answering #46 is optional. By answering, you re 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

Hanover, NH

Adjuinct Faculty

200

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

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)

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

Note: Answering #47 is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

None reported

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

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

Note: Answering #48 is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your professional or community service activities and awards.

None reported

(Activities or Awards)

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

What is the location of your primary practice setting?

6 Bobcats. North Rutland, VT.

Town/City, State

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

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location? ■ Yes ☐ No

If yes, please describe the translating services available: **None**

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

A. Medicaid participation
Do you participate in the Medicaid program? ☒ Yes ☐ No

B. New Medicaid Patients
Are you currently accepting new Medicaid patients? ☒ Yes ☐ No

Part V

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

Date: 11/20/09

Anne Hilder PAC
Applicant's Signature

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

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Gibson (Last) Cheryl (First) A (Middle)

Mailing Address Planned Parenthood (Office Name)
23 Mansfield Ave. (Street)
Burlington, VT. 05401 (City/State) (Zip Code) 863-9001 (Telephone Number)

Vermont License #: 042-0007465

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Fletcher Allen Health Care	Burlington	OB/GYN

What arrangements have you made for supervision when you are not available or out of town:

24/7 on call service / covered by two M.D's.

CERTIFICATE OF SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Anne Hildreth, P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.

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

12/22/09 (Date)

(Signature of Supervising Physician)

Co-signature of PA: X Anne Hildreth PA-C

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MH0195986

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Smith (Last) Susan (First) – (Middle)

Mailing Address Planned Parenthood (Office Name)
23 Mansfield Ave. (Street)
Burlington, VT. 05401 863-9001
(City/State) (Zip Code) (Telephone Number)

Vermont License #: 042-0005990

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
FAHC	Burlington	OB/GYN

List all physician's assistants names and addresses you currently supervise:
Amy Borgman 90 Washington St. Barre, VT.
Johanna Hauser 23 Mansfield Ave Burl. VT.
Anne Hildreth 6 Roberts North Rutland, VT. (NP) →

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

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

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

12/29/09 (Date)

Susan O Smith (Signature of Secondary Supervising Physician)

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Bayman (Last) Kym (First) M (Middle)

Mailing Address Planned Parenthood (Office Name)
23 Mansfield Ave. (Street)
Burlington, VT. 05401 863-9001
(City/State) (Zip Code) (Telephone Number)

Vermont License #: 042001059M

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
FAHC	Burlington, VT.	OB/GYN

List all physician's assistants names and addresses you currently supervise:
Amy Bergman 90 Washington St. BARRE, VT.
Johanna Hauser 23 Mansfield Ave. Burl. VT.
Anne Hildreth 6 Roberts No. Rutland, VT.

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

OVER →

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

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

1-5-10
(Date)

(Signature of Secondary Supervising Physician)

Vermont Department of Health — Board of Medical Practice

108 Cherry Street, P.O. Box 70

Burlington, VT 05402-0070

http://healthvermont.gov/hc/med_board/bmp.aspx

802-657-4220

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

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

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

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

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

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

☐ I consent _____ _____

Signature Date

_____ _____

Print Name Vermont License or Certification Number

Print Mailing Address _____

_____

Telephone _____

NCCPA

National Commission on Certification of Physician Assistants

November 21 2009

**********AUTO**MIXED AADC 550 T105 P1

278436

Anne Sarver Hildreth

[redacted]

Dear Physician Assistant-Certified designee:

Enclosed you will find your NCCPA wallet card for your next two-year certification cycle. Please note two important pieces of information: your Dec. 31, 2011 certification expiration and your 7-digit NCCPA identification number.

In our technologically-savvy world, the risk of fraudulent use and falsification of paper documentation is increasing. Thus, to help safeguard the integrity and security of the PA-C credential, NCCPA has eliminated the paper certificates once issued to PAs every two years. This change to issuing only a wallet card is aimed at curtailing the use of the printed certificate as proof of certification. The only valid proof of NCCPA certification is primary source verification through the NCCPA.

We encourage you to use the Verify PA Certification tool on our Web site (www.nccpa.net). This tool allows you, your employer, state licensing board or others to obtain the primary source verification that you need with just a few clicks, provided at no cost to you. The tool provides you the flexibility to print the Web screen, request an e-mailed PDF file or a mailed letter. The tool also offers you the flexibility to have NCCPA submit your certification information directly to a third party by entering their contact information.

For those desiring a document appropriate for display commemorating your achievement of NCCPA certification, we provide such a document that has no expiration date. If you are interested in receiving one, please contact us at nccpa@nccpa.net.

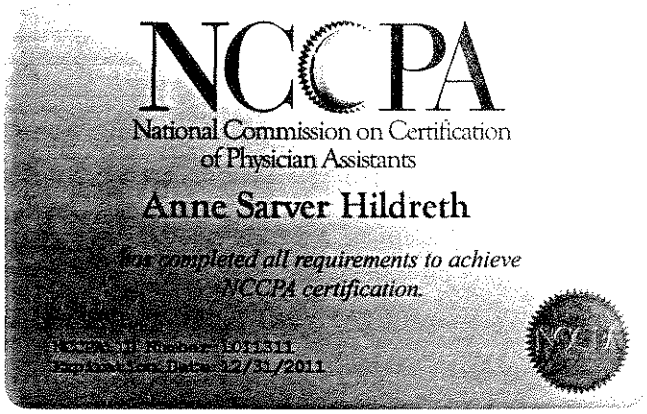
Please note that for your 2009-2011 certification maintenance cycle, the deadline for earning and logging the required CME hours and paying the certification maintenance fee is **June 30, 2011** to receive the **$50 discount**. Log your hours online at www.nccpa.net as you earn them to keep a running total. While there, you can also view a personalized record of all your certification maintenance requirements.

Sincerely,

Cindy L. Nalls

Cindy L. Nalls
Manager of Certification Maintenance

P.S. NCCPA is making a conscious effort to protect the environment. As part of our efforts, we are "**going green**". With that in mind, as of the 2008-2010 certification maintenance cycle, we are no longer accepting paper logging forms. Please don't hesitate to contact us for assistance if you are new to our online CME logging process.



12000 Findley Road · Suite 200 · Duluth · Georgia · 30097 · Tel: 678.417.8100 · Fax: 678.417.8135 · Web: www.nccpa.net

Planned Parenthood®
of Northern New England

serving
Maine,
New Hampshire,
& Vermont

CENTRAL OFFICE
183 Talcott Road, Suite 101, Williston, VT 05495
Phone 802-878-7232 ■ Fax 802-878-8001

December 17, 2009

State of Vermont-Board of Medical Practice
Attn: Tracy Hayes
108 Cherry Street
Burlington, VT 05401

Dear Ms. Hayes,

This letter is to certify that the Physician Assistant named below has practiced under my supervision, in Vermont, within the last twelve months:

- Anne Hildreth

In addition, the Physician's Assistant named above maintains a Drug Enforcement Agency certification, and will be authorized to prescribe medications in accordance with Planned Parenthood's Scope of Practice, which has been submitted to and approved by the Vermont Board of Medical Practice.

Sincerely,

Cheryl Gibson, M.D

PHYSICIAN ASSISTANT SCOPE OF PRACTICE
at Planned Parenthood of Northern New England

Planned Parenthood of Northern New England's Scope of Practice for Physician's Assistants consists of several documents:

1) PPNNE Standing Orders: Each P.A. practitioner annually signs the Standing Orders that are approved by PPNNE's Medical Advisory Committee then co-signed by PPNNE's Medical Director. Standing Orders define the prescriptive and medical authority of the P.A. practitioner at PPNNE.

2) PPNNE's Medical Protocol: The exact duties of the P.A. are clearly defined in PPNNE's Medical Protocol, a copy of which is on file with the Vermont Board of Medical Practice.

3) Medical Oversight at PPNNE: Please refer to the attached document, Medical Oversight at PPNNE, for information about the structure of supervision of P.A.'s at PPNNE.

4) Additional information about PPNNE's health centers, patient population and P.A. practice at Planned Parenthood of Northern New England:

   Planned Parenthood of Northern New England is a non-profit health care organization with thirteen outpatient health centers in Vermont. Under the supervision of PPNNE's Medical Director, Physician's Assistants at PPNNE health centers provide outpatient gynelogical and preventive care for women and men as outlined in PPNNE's Standing Orders and Medical Protocols.

   Many of our sites are located in rural areas where access to health care may be difficult. PPNNE offers a sliding fee scale based on the individual's ability to pay. Our commitment to providing services regardless of a client's ability to pay means that thousands of Vermonters without health insurance have access to high quality reproductive and preventive health care.

   As specified in Section I, Part I of the PPNNE Medical Protocol, each clinic site is required to inform patients how to obtain care in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinic as well as the medical back-up arrangements with a physician or hospital.

Physician Assistant (ANNE Hindreth) — Date 12/10/09

Supervising Physician — Date 12/22/09

The Family Planning Practitioner may:

A. Provide information and counseling on: family planning methods; sterilization; pregnancy; adoption; abortion; common gynecological problems; sexually transmitted diseases; sexual assault; male reproductive health; infertility; midlife health; general preventive health care.

B. 1) Order and dispense hormonal contraceptives and HT/ET in accordance with the PPNNE Medical Protocol.
2) Manage routine hormonal contraceptive and HT/ET problems.
3) Order special laboratory tests needed to prescribe hormonal contraceptives and HRT.

C. 1) Insert and remove implant contraceptive systems in accordance with the PPNNE Medical Protocol.
2) Manage routine implant system problems.

D. 1) Inject Medroxyprogesterone acetate in accordance with PPNNE Medical Protocol.
2) Manage routine DMPA problems.

E. 1) Insert and remove IUD's in accordance with the PPNNE Medical Protocol.
2) Manage routine IUD problems.
3) Order X-rays and sonograms for IUD localization.

F. 1) Fit and check diaphragms, cervical caps and other barrier devices in accordance with the PPNNE Medical Protocol.
2) Manage diaphragm, cervical cap and other barrier device problems.

G. 1) Order and dispense condoms and vaginal spermicides in accordance with the PPNNE Medical Protocol.
2) Manage condom and spermicide problems.

H. Counsel and provide continuing evaluation and support of the natural methods of birth control: BBT, sympto-thermal, cervical mucus and calendar.

I. Evaluate patient history, perform elementary physical examination and pelvic examination, order and evaluate laboratory and other tests as indicated and administer immunizations and other medications in accordance with the PPNNE Medical Protocol.

J. Order, administer and/or dispense medications in accordance with the PPNNE Medical Protocol and state and federal laws.

K. Diagnose and order or dispense treatment for conditions covered in the PPNNE Medical Protocol as indicated in the protocol.

L. Perform pregnancy diagnosis as per the PPNNE Medical Protocol. Order serum HCG pregnancy test, and sonograms.

M. Provide services to patients in the abortion, cervical dysplasia, infertility, male services, and midlife programs as per the PPNNE Medical Protocol and Medical Protocol Supplements.

N. Provide routine gynecologic and general preventive health care as per the PPNNE Medical Protocol. Manage and follow-up routine and problem patients in accordance with the PPNNE Medical Protocol.

O. Perform venipuncture; start and maintain I.V.'s.

P. Order and follow-up on outside laboratory tests and dispense treatment for conditions not specifically covered in the PPNNE Medical Protocol under the direct guidance of a PPNNE physician with the Medical Director's approval.

Q. Pursuant to delegation from the Medical Director, to provide reproductive health care to minors, including and especially contraception and diagnosis and treatment of sexually transmitted infections, as indicated with or without parental consent if the minor may suffer probable health hazards if such services are not provided.

The Family Planning Practitioner must:

A. Adhere to the PPNNE Medical Protocol.
B. Obtain physician consultation in all non-routine clinical matters.
C. Follow-up and report all complications and all potential medico-legal incidents to the Medical Director.

I agree to practice under the above standing orders

Anne Hildreth
Print Name

Anne Hildreth PAC 2/27/09
Signature Date

Collaborating Physician: Cheryl Gibson, MD, Medical Director

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: Anne Hilder PAC

Date: 1/12/10

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 12/16/09

[signature] 1/12/10

NCCPA

National Commission on Certification of Physician Assistants

Anne Sarver Hildreth

has completed all requirements to achieve NCCPA certification.

NCCPA ID Number 1011311
Expiration Date 12/31/2011

Anne Hildreth PA-C

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

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

RECEIVED
JAN 14 2010

Date: January 8, 2010

Dear Physician Assistant:

Your 2010 Physician Assistant certification renewal application has been received by this office and cannot be processed until the following information is received.

- ☐ $115 renewal fee
- ☐ $50 renewal fee
- ☐ Additional $65 renewal fee

Application

Part I

- ☐ Item 1
- ☐ Item 2
- ☐ Item 3
- ☐ Item 4
- ☐ Item 5
- ☐ Item 6
- ☐ Item 7
- ☐ Item 8
- ☐ Item 9
- ☐ Item 10
- ☐ Item 11
- ☐ Item 12
- ☐ Item 13
- ☐ Item 14
- ☐ Item 15
- ☐ Item 16
- ☐ Item 17
- ☐ Item 18
- ☐ Item 19
- ☐ Item 20
- ☐ Item 21
- ☐ Item 22

Part II

- ☐ Item 23
- ☐ Item 24
- ☐ Item 25
- ☐ Item 26
- ☐ Item 27
- ☑ Item 28
- ☐ Item 29
- ☐ Item 30
- ☐ Item 31
- ☐ Item 32

Part III

- ☐ Item 33
- ☐ Item 34
- ☐ Item 35
- ☐ Item 36
- ☐ Item 37

Part IV

- ☐ Item 38
- ☐ Item 39
- ☐ Item 40
- ☐ Item 41
- ☐ Item 42
- ☐ Item 43A
- ☐ Item 43B
- ☐ Item 44A
- ☐ Item 44B
- ☐ Item 45
- ☐ Item 46A
- ☐ Item 46B
- ☐ Item 47
- ☐ Item 48
- ☐ Item 49
- ☐ Item 50
- ☐ Item 51A
- ☐ Item 51B

Part V

- ☐ Date
- ☐ Signature

Child Support, Taxes, Unemployment Compensation Statement

- ☐ Number 1 – check one of the two statements
- ☐ Number 2 – check one of the two statements
- ☐ Number 3 – check one of the three statements

Need Dr's signature

- ☐ Completed form A
- ☑ Completed Statement of Good Standing

Supervising Physician Forms

- ☐ Primary Supervising Physician Application
- ☐ Secondary Supervising Physician Application(s)
- ☐ Primary Supervising Physician Letter stating work for past year
- ☐ Scope of Practice

NCCPA Certification

- ☐ Proof of NCCPA Certification (copy of NCCPA certificate)

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

Thank you.

Enclosures

30584

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Theiler (Last) Regan (First) Neil (Middle)

Mailing Address 23 Mansfield Avenue (Office Name)

(Street)

Burlington (City/State) VT 05401 (Zip Code) 863-6326 (Telephone Number)

Vermont License #: 042-0012264

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Application in process with F.A.H.C		OB/Gyn

What arrangements have you made for supervision when you are not available or out of town:

24/7 on call Service

CERTIFICATE OF SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Anne Hildreth, P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.

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

8/2/11 (Date) (Signature of Supervising Physician)

X Co-signature of PA: Anne Hildreth PA-C

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MH1787956

30584

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

APR 20 2011

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Toivanen Kathleen Marie
(Last) (First) (Middle)

Mailing Address Planned Parenthood
(Office Name)
183 Talcott RD
(Street)
Williston, VT 05495 288-8432
(City/State) (Zip Code) (Telephone Number)

Vermont License #: 042-0012163

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Portsmouth Regional Hospital	Portsmouth, NH	OB/Gyn

What arrangements have you made for supervision when you are not available or out of town:

24/7 on call service

CERTIFICATE OF SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Anne Hildreth, P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.

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

4/11/11
(Date)

X Kathleen M. Toivanen
(Signature of Supervising Physician)

Co-signature of PA X Anne Hildreth

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MH1787956

APR 20 2011

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Novello Renee
(Last) (First) (Middle)

Mailing Address Planned Parenthood
(Office Name)
183 Talcott Road
(Street)
Williston, VT. 05495 288-8432
(City/State) (Zip Code) (Telephone Number)

Vermont License #: 042-0011195

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Mt. Ascutney Hospital	Windsor, VT.	OB/Gyn
DHMC	Lebanon, NH	OB/Gyn

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

Johanna Hauser 23 Mansfield Ave. Burlington, VT.
Catherine Nicholas " " " " "
Janet Young " " " " "

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

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

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

4/13/11
(Date)

X [signature]
(Signature of Secondary Supervising Physician)

75584

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Novello Renee —
(Last) (First) (Middle)

Mailing Address Planned Parenthood
(Office Name)
6 Roberts North
(Street)
Rutland, VT. 05701 775-2333
(City/State) (Zip Code) (Telephone Number)

Vermont License #: 042001195

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
MT. Ascutney Hosp.	Windsor, VT	OB/Gyn
DHMC	Lebanon, NH	OB/Gyn

What arrangements have you made for supervision when you are not available or out of town:

24/7 ON Call Service

CERTIFICATE OF SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Anne Hildreth, P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.

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

3/4/2011
(Date)

(Signature of Supervising Physician)

Co-signature of PA: Anne Hildreth PA

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MV2265191

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MAR 17 2011

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Gibson (Last) Cheryl (First) A (Middle)

Mailing Address Planned Parenthood (Office Name)
183 Talcott RD. (Street)
Williston, VT (City/State) 05495 (Zip Code) 288-8432 (Telephone Number)

Vermont License #: 0420007465

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
FAHC	Burlington, VT.	OB/GYN

List all physician's assistants names and addresses you currently supervise:
Amy Borgman 90 Washington St. Barre, VT. 05641
Johanna Hauser 23 Mansfield Ave. Burlington, VT. 05401
Anne Hildreth 6 Roberts NO. Rutland, VT. 05701

(OVER) →

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

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

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

3/3/11 (Date)

X (Signature of Secondary Supervising Physician)

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

pd 20.00

2012 PHYSICIAN ASSISTANT LICENSURE RENEWAL APPLICATION

PART I

RECEIVED
JAN 16 2012

License # 055-0030584

1. Name: Anne Sarver Hildreth PA-C

2. Other Name(s), if any, under which you were certified or licensed in Vermont and elsewhere:

_____

3. Mailing Address(es):

[redacted]

4. Home Address: [redacted]

City, State, Zip Code: [redacted]

5. Email Address: [redacted]

6. Daytime Telepho[redacted]

7. Date of Birth:

[redacted]

8. Place of Birth: [redacted]

9. Certification Examination Taken – (Check box and enter date of examination):

- ☐ (2007) NCCPA - Due 2013 -
- ☐ (___/___/___) State Examination-Identify state:_____
- ☐ (___/___/___) Other Examination specify: National Cert.

055003058 4

10. Basis for Vermont Certification – (Check box):

- ☐ Apprenticeship Trained
- ☒ University Trained

11. Do you have hospital privileges in Vermont? ☐ Yes ☒ No
Hospital Name(s) and Location(s):

_____
_____
_____
_____

12. In what year did you start working as a physician assistant in Vermont? _____

13. Were you in active clinical practice in Vermont during the past 12 months? ☒ Yes ☐ No

14. Other states where you now hold an active certification or license to practice: N.H.

15. States where you previously were certified or licensed to practice: N.H. MA.

16. Specialty: OB/GYN DEA Number: MH0195986

17. Name and office address of current EMPLOYER(S):

PPNNE, ~~23 Mansfield Avenue, Burlington, VT 05401~~ ← 128 Lakeside Ave, Suite 3C

Name Address Burlington, VT. 05408

18. Please list (use additional sheet if necessary) name(s) and address(es) of physicians who currently serve as your PRIMARY and SECONDARY SUPERVISING PHYSICIAN(S). Attach signed sheets for each practice location.

Primary Supervising Physician(s):

Name Address

Secondary Supervising Physician(s):

Name Address

19. Delegation Agreement: The Board of Medical Practice requires that you and your primary supervising physician(s) review the most current delegation agreement for your practice setting, paying attention to any additions or deletions in duties and procedures. Please review, date and sign your delegation agreement and have your PRIMARY SUPERVISING PHYSICIAN sign it as well. Attach a copy of your signed delegation agreement to this application. This should be done for each practice location and included with this renewal.

a. Has there been a change in your delegation agreement which has not been reviewed by the Board?
☐ Yes ☐ No

20. Please provide a letter from your Supervising Physician attesting to the fact that you have practiced as a Physician Assistant within the past twelve months.

21. Continuing Medical Education (CME) requirements:

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

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

22. Primary Supervising Physician and Second Supervisory Physician forms are provided. They must be completed and returned with this application.

PART II

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

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

055 00305
84

□ yes ☒ no Anne Hildreth 055-0030584

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

32. 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

33. 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.

34. To your knowledge, are you the subject of an investigation by any other licensing board under which you have not been charged as of the date of this application? [redacted]

35. 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 36 through 38.

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

"Medical condition" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited

to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

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

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

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

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

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

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

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

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

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

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

IMPORTANT

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

Part IV - Statutory Profile Questions

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

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 39 through 44 have changed since your last application. We cannot process your application without them.

39. Criminal Convictions [See 26 VSA § 1368(a)(1)] X Check here if none

Anne Hicaret
0550830584

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past 10 years **Please provide complete copies of documentation for each matter.**

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

40. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)] ☒ 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. **Please provide complete copies of documentation for each matter.**

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

41. Vermont Board of Medical Practice Matters [See 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.

(Date) (Final Disposition - Summary)

42. Licensing or Certification Authority Matters in Other States [See 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. **Please provide complete copies of documentation for each matter.**

RECEIVED JAN 24 2012

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

43. Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)] ☒ Check here if none

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 complete copies of documentation for each matter.**

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

B. Other Restrictions ☒ Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. **Please provide complete copies of documentation for each matter.**

(Date) (Hospital) (State)

AnneHilliard 0550030584

(Nature of Action) (Action) _____ ☐ In lieu
☐ In settlement
(Reason for Action)

44. Medical Malpractice Court Judgments/Settlements [See 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

☐ Judgment ☐ Arbitration

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

☐ Judgment ☐ Arbitration

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

B. Settlements ☒ Check here 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

(Date) (Court) (State) (Amount of Settlement Against You)

(Date) (Court) (State) (Amount of Settlement Against You)

45. Years of Practice [See 26 VSA § 1368(a)(10)] **1984**

What month and year did you start practicing as a Physician Assistant? June 1984

46. Appointments/Teaching [See 26 VSA § 1368(a)(12)] Note: Answering #46 is optional. By answering, you re 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

Hanover, NH

Adjuinct Faculty Anne Hildreth 0550030584

200

Franklin Pierce PAC Prog. Cardiovascular Proctor 2010-2011
(School) (City) (State) (Nature of Appointment) From (year) To (year)

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

B. Teaching

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

Franklin Pierce PAC Prog. W. Lebanon, NH 2010-2011
(School/Institution) (City) (State) (Nature of Teaching) From (year) To (year)

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

Note: Answering #47 is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

None reported

(Title)
(Publication) (Year)

(Title)
(Publication) (Year)

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

Note: Answering #48 is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your professional or community service activities and awards.

None reported

(Activities or Awards)

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

What is the location of your primary practice setting?
West Lebanon, NH 03784
Town/City, State

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

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location? ☒ Yes ☐ No

If yes, please describe the translating services available: **None**

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

A. Medicaid participation
Do you participate in the Medicaid program? ☒ Yes ☐ No

B. New Medicaid Patients

Are you currently accepting new Medicaid patients? ☒ Yes ☐ No

Part V

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

Date: 11/11/11

Applicant's Signature

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

#

055. 0030584

State of Vermont

Department of Health

Board of Medical Practice

Statement of Good Standing

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

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

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

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

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

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

Signature: _____

Date: 11/11/11

055.0030584

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer questions 1 and 2

Regarding Child Support

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".

   ☐

Social Security # [redacted] Date of Birt [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 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 11/11/11

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

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Theiler (Last) Regan (First) Nell (Middle)

Mailing Address Planned Parenthood of Northern New England (Office Name)
183 St. Paul Street (Street)
Burlington, VT (City/State) 05401 (Zip Code) 802-863-6326 (Telephone Number)

Vermont License #: 042-0012264

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Fletcher Allen Health Care	111 Colchester Ave. Burlington, VT 05401	OB\GYN

What arrangements have you made for supervision when you are not available or out of town:
24/7 on call service

CERTIFICATE OF SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Anne Hildreth, P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.

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

12/2/11 (Date)

(Signature of Supervising Physician)

Co-signature of PA: Anne Hildreth

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MH1787956

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Novello (Last) Renee (First) J. (Middle)

Mailing Address Planned Parenthood of Northern New England (Office Name)
6 Roberts North (Street)
Rutland, VT (City/State) 05701-3120 (Zip Code) 802-775-2333 (Telephone Number)

Vermont License #: 042-0011195

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Mt. Ascutney Hospital and Health Center	289 County Road Windsor, VT 05089	OB/GYN

List all physician's assistants names and addresses you currently supervise:
Amy Borgman, 90 Washington St., Barre, VT 05641
August Burns, 213 E. Main St, Hyde Park, VT 05655
Johanna Hauser, 183 St. Paul St., Burlington, VT 05401

→ over

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

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

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

12/15/11
(Date)

(Signature of Secondary Supervising Physician)

Anne Hildreth, 90 Washington St., Barre, VT 05641
Sarah Vensel, 183 St. Paul St., Burlington, VT 05401
Janet Young, 183 St. Paul St., Burlington, VT 05401

RW

Planned Parenthood®
of Northern New England

serving
Maine,
New Hampshire,
& Vermont

Scope of Practice
And
Plan of Supervision
at Planned Parenthood of Northern New England

Planned Parenthood of Northern New England's Scope of Practice for Physician Assistants consists of several documents:

1) PPNNE Standing Orders: Each P.A annually signs the Standing Orders that are approved by PPNNE's Medical Advisory Committee then co-signed by PPNNE's Medical Director. Standing Orders define the prescriptive and medical authority of the P.A at PPNNE.

2) Medical Oversight at PPNNE: Please refer to the attached document, Medical Oversight at PPNNE, for information about the structure of supervision of P.A's at PPNNE.

3) The Primary or Secondary Supervising Physician will have scheduled charts review for each Physician Assistant throughout the duration of their employment at PPNNE.

4) Additional information about PPNNE's health centers, patient population and P.A's at Planned Parenthood of Northern New England:

   Planned Parenthood of Northern New England is a non-profit health care organization with health centers in Vermont, Maine and New Hampshire. Under the supervision of PPNNE's Medical Director, P.A's at PPNNE health centers provide outpatient gynelogical and preventive care as outlined in PPNNE's Standing Orders and Medical Protocols.

   Many of our sites are located in rural areas where access to health care may be difficult. PPNNE offers a sliding fee scale based on the individual's ability to pay. Our commitment to providing services regardless of a client's ability to pay means that thousands of Vermonters without health insurance have access to high quality reproductive and preventive health care.

   As specified in Section I, Part I of the PPNNE Medical Protocol, each clinic site is required to inform patients how to obtain care in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinic as well as the medical back-up arrangements with a physician or hospital.

Anne Hildreth
P.A

Date 12/20/11

Regan Theiler M.D
Supervising Physician

Date 12/2/11

Personal Certification Record

Anne Sarver Hildreth

NCCPA Identification #: 1011311

Initial Certification Date: January 15, 1983
Expiration Date: December 31, 2011

Your Contact Info

Address: > Make corrections

[redacted]

E-mail: [redacted]

You have completed all requirements for the 2009-2011 cycle. Your certification will be updated in December 2011.

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

CME Info

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

Earning CME for the 2009-2011 cycle begins on 05/01/2009 and ends on 12/31/2011.

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

You have logged all required CME for the 2009-2011 cycle.

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

> Log New CME > View CME Summary

Exam Notes

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

Your 5th Year: 2012 Your 6th Year: 2013

Fees & Payments

You do not have an outstanding balance for the 2009-2011 cycle.

Legal

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

Important Dates & Deadlines

05/01/2011: First day to start earning CME for the 2011-2013 cycle.

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

12/31/2013: Last day to fulfill any outstanding certification maintenance requirements for the 2011-2013 cycle.

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

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

Anne Hildreth PA

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

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

Date: January 17, 2012

Dear Physician Assistant:

Your 2012 Physician Assistant License renewal application has been received by this office and cannot be processed until the following information is received.

- ☐ $170 renewal fee

Application

Part I
- ☐ Item 1
- ☐ Item 2
- ☐ Item 3
- ☐ Item 4
- ☐ Item 5
- ☐ Item 6
- ☐ Item 7
- ☐ Item 8
- ☐ Item 9
- ☐ Item 10
- ☐ Item 11
- ☐ Item 12
- ☐ Item 13
- ☐ Item 14
- ☐ Item 15
- ☐ Item 16
- ☐ Item 17
- ☐ Item 18
- ☐ Item 19
- ☐ Item 20

Part II
- ☐ Item 21
- ☐ Item 22
- ☐ Item 23
- ☐ Item 24
- ☐ Item 25
- ☐ Item 26
- ☐ Item 27
- ☐ Item 28
- ☐ Item 29
- ☐ Item 30
- ☐ Item 31
- ☐ Item 32

Part III
- ☐ Item 33
- ☐ Item 34
- ☐ Item 35
- ☐ Item 36
- ☐ Item 37

Part IV
- ☐ Item 38
- ☐ Item 39
- ☐ Item 40
- ☐ Item 41
- ☐ Item 42
- ☐ Item 43A
- ☐ Item 43B
- ☐ Item 44A
- ☐ Item 44B
- ☐ Item 45
- ☐ Item 46A
- ☐ Item 46B
- ☐ Item 47
- ☐ Item 48
- ☐ Item 49
- ☐ Item 50
- ☐ Item 51A
- ☐ Item 51B

Part V
- ☐ Date
- ☐ Signature

Child Support, Taxes, Unemployment Compensation Statement
- ☐ Number 1 – check one of the two statements
- ☐ Number 2 – check one of the two statements

- ☐ Completed form A
- ☐ Completed Statement of Good Standing

Supervising Physician Forms
- ☐ Primary Supervising Physician Application
- ☐ Secondary Supervising Physician Application(s)
- ☐ Delegation Agreement

NCCPA Certification
- ☐ Proof of NCCPA Certification

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

Thank you.

Enclosures

Renewal - 055.0030584

Name	Anne Sarver Hildreth
Credential	055.0030584

Fee Details

Renewal	$170.00
	$170.00

Renewal Introduction

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

Physician Assistant License Renewal

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

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

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

Be sure to complete, submit or upload:

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

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

Please Note:
Licensees have a continuing obligation during each two-year renewal period to promptly notify the Board of any change or new information including, but not limited to, disciplinary or other action limiting or conditioning their license or ability to practice in any jurisdiction. Failure to do so may subject the licensee to disciplinary action by the Board.
Thank you.

Renewal Part I

1. Last Name:
   Hildreth

2. First Name:
   Anne

3. Middle Name:
   Sarver

4. All other names used:

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

5. Enter your MAILING ADDRESS information:

Attention

Street [redacted]

City [redacted] **State** [redacted] **Zip** [redacted] **Country** United States

E-mail Address [redacted]

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

6. Enter your PUBLIC ACCESS address information:

Attention PPNNE

Street 128 Lakeside Avenue

City Burlington **State** VT **Zip** 05408

Country United States

Telephone

E-mail Address

Alternate Phone (e.g. Pager)

7. Date of Birth:
[redacted]

8. Birth City:
[redacted]

9. Birth State/Province:
[redacted]

10. Birth Country:
United States

11. Select the certification examination taken (verification must be sent directly to this office from the Examining Agency):
University Trained - NCCPA Examination

12. Date NCCPA Examination was taken (if applicable):
12/18/2013

13. Date VT Apprenticeship Examination was taken (if applicable):

14. Basis for Vermont Certification:
University Trained

15. Do you have hospital privileges in Vermont?
No

16. List all hospitals where you have, or previously have had, privileges:

Facility Name	State	Start Date

17. In what year did you start working as a physician assistant in Vermont?
2012

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

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

20. Specialty:
OB/GYN

21. DEA Number:
MH0195986

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

Supervisor	Relationship Type	Practice Location
042.0012264 : THEILER REGAN	Primary Supervising Professional	PPNNE
042.0011195 : NOVELLO RENEE	Secondary Supervising Professional	PPNNE

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

DO Supervisor	Relationship Type	Practice Location

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

Continuing Medical Education (CME) Requirements

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

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

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

Renewal Part II

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

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

28. State:

29. Year:

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

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

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

33. State:

34. Year:

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

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

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

38. State:

39. Year:

40. Circumstances:

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

42. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
No

43. Name of organization involved:

44. Date:

45. Duration:

46. Action Taken (add all that apply):

47. Circumstances:

48. Disciplinary charges or actions - Upload documents:

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

50. State:

51. Circumstances under which examination privileges denied:

52. Denial of examination privileges - Upload documents:

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

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

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

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

57. Training program(s):

58. Location of program(s):

59. Year:

60. Circumstances:

61. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?
No

62. Institution involved:

63. Location:

64. Year:

65. Circumstances:

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

67. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
No

68. Name of organization involved:

69. Type of restriction:

70. Date:

71. Circumstances:

72. Privilege to prescribe controlled substances - Upload documents:

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

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

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

76. Court:

77. City and state:

78. Charge:

79. Description:

80. Status:

Renewal Part III

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

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

81. To your knowledge, are you the subject of an investigation by any other licensing or certification board under which you have not been charged as of the date of this application?

82. Licensing or certification board:

83. Date:

84. Location of Licensing Board:

85. Circumstances:

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

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

88. Court:

89. City and state:

90. Charge:

91. Description:

92. Status:

93. Date:

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

MEDICAL QUESTIONS

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

answers.

DEFINITIONS

In answering the following questions, please use these definitions:

"Ability to practice medicine" - This term includes:

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.

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

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

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

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

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

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

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

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

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

IMPORTANT

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

Renewal Part IV

Statutory Profile Questions

Vermont law, 26 VSA § 1368, creates a data repository within the Department of Health. Under this law, the Department must collect certain information to create individual profiles on all health care professionals licensed, certified, or registered by the Department pursuant to Title 26 of the VSA. Please try to answer the following questions as best as you can.

104. **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

105. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted. For purposes of this question, “convicted” means that you pleaded guilty or that you were found adjudged guilty by a court of competent jurisdiction. **Please provide copies of papers fully documenting the convictions.**

Date of Conviction	Court of Conviction	City	State	Description

106. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]
Have there been any charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without finding by a court of competent jurisdiction?
No

107. Nolo Contendere/Matters Continued [See 26 VSA § 1368(a)(2)]
Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continue without finding by a court of competent jurisdiction.

Date of Charges	Court	City	State	Description of Charges

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

109. Vermont Board of Medical Practice Matters [See 26 VSA § 1368(a)(3)]
Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipluations), and final disposition of such matters by the courts, if appealed.

Date	Final Disposition Summary

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

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

Date of Disposition	Licensing Authority	City	State	Description of Disposition

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

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

113.
A. Revocation/Involuntary Restrictions
Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. Please upload copies of papers fully documenting these matters.

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

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

115.
B. Other Restrictions
Please provide a description of all resignations from, or nonrenewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. Please upload copies of papers fully documenting these matters.

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

116. **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

117.
A. Judgments
Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you, and any pending malpractice cases.

Date of Judgment

118.
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.**

119. **Years of Practice**
What year did you start practicing as a medical professional?
1983

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

Facility Name	City	State	Start Date	End Date

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

121.
A. Appointments
Please provide information about your appointments to medical school or professional school facilities.

School	City	State	Nature of Position	Date Started	Date Ended
Dartmouth	Hanover	New Hampshire	Adjuinct Faculty		
Franklin Pierce University	Lebanon	New Hampshire	Perdieum Proctor	01/01/2010	01/01/2011

122.
B. Teaching

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

School / Institution	City	State	Nature of Teaching	Date Started	Date Ended
Frankling Pierce University	Lebanon	New Hampshire	Proctor	01/01/2010	01/01/2011

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

Title	Publication	Publication Date

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

Activity or Award

125. 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?
PPNNE	Burlington	Vermont	Yes		Yes	Yes

Statement of Good Standing

126.

State of Vermont
Department of Health
Board of Medical Practice

Statement of Good Standing

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

I hereby state that either:

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

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

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

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

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

Yes

127. Date:
01/13/2014

Statement Regarding Child Support, Taxes

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer these questions.

Regarding Child Support

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

128. You 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)

129. 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.

130. Social Security Number:
[redacted]

131. Date of Birth:
[redacted]

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

133. Date:
01/13/2014

Workforce Survey

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

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

Renewal Payment

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

Review

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

RECEIVED
JAN 15 2014
Vermont Board of Medical Practice

PRIMARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Burkett (Last) Donna (First) (Middle)

Mailing Address Planned Parenthood of NNE (Office Name)
128 Lakeside Ave, Suite 301 (Street)
Burlington, VT (City/State) 05401 (Zip Code) 802-448-9717 (Telephone Number)

Vermont License #: 042.0012729

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Pending - Fletcher Allen	Burlington, VT	Family Practice

What arrangements have you made for supervision when you are not available or out of town:
Strong relationship with UVM + FAHC Family Medicine + OB/GYN departments, who will care for patients in the rare instance they need hospitalization + I am not available.

CERTIFICATE OF SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of Anne Hildreth, P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.

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

12/19/13 (Date)

(Signature of Supervising Physician)

Co-signature of PA:

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number MH1787956

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

SECONDARY SUPERVISING PHYSICIAN APPLICATION

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

Name in full Novello (Last) Renee (First) (Middle)

Mailing Address Planned Parenthood of NNE (Office Name)
128 Lakeside Ave, Suite 301 (Street)
Burlington, VT (City/State) 05401 (Zip Code) 802-448-9719 (Telephone Number)

Vermont License #: 042-0011195

Hospital(s) where you have privileges:	Hospital(s) Location	Specialty
Dartmouth Hitchcock	Lebanon, NH	OB/GYN

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

Amy Borgman 90 Washington St, Barre, VT 05641
Erin Haynes 4 Bowdoin Mill Island Ste 101, Topsham, ME 04086
Amy Corey 80 Fairfield St, St. Albans, VT 05478
Jennifer Moriarty-Lowen 24 Pennacook St, Manchester, NH 03104

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

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

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

12/15/13 (Date)

(Signature of Secondary Supervising Physician)

Planned Parenthood®
of Northern New England

Physician Assistant Delegation Agreement

Narrative:

Planned Parenthood of Northern New England is a non-profit health care organization with health centers in Vermont, Maine and New Hampshire. Under supervision of PPNNE's Medical Director, P.A.s at PPNNE health centers provide outpatient gynecological and preventive care.

Supervision:

All PPNNE practitioners undergo a thorough orientation to PPNNE and our medical protocol before function in an independent capacity. If further training in any expected area of competence is needed, this is arranged and takes place through on-line courses, live and recorded webinars and in-person trainings, including longitudinal proctoring, as needed.

The Medical Director, a board certified Family Practice MD, is the primary supervising physician, and provides oversight and supervision through on-site visits and consultations, telephone and written consultations and in-services. The secondary supervising physician is a board certified OB/GYN MD, and provides oversight and supervision in the same manner as the Medical Director. Medical back-up is available by telephone on a 24-hour basis. In addition, the Medical Director works with the Medical Clinical Quality Improvement Team and the Director of Quality and Risk Management to develop and review protocols, audits, and to evaluate any new developments in the medical field that may affect PPNNE.

All PPNNE mid-level practitioners practice under Medical Standards and Guidelines, as well as Standing Orders developed by the Medical Director. Practitioners attend continuing education in-service for medical training, discussion of protocol questions and other practice concerns, as well as attending outside CME conferences. In addition, we have community physicians who are available to our staff for consultation, telephone back-up and review of charts.

Sites of Practice:

PPNNE's Physician Assistants see patients throughout Vermont, Maine and New Hampshire. Many of our sites are located in rural areas where access to health care may be difficult. PPNNE offers a sliding fee scale based on the individual's ability to pay. Our commitment to providing services regardless of a client's ability to pay means that thousands of Vermonters without health insurance have access to high quality reproductive and preventive health care.

Each PPNNE site is required to inform patients how to obtain care in the event of an emergency. Sites providing surgical services must also document a plan for handling emergencies occurring in the clinics as well as medical back-up arrangements with a physician or hospital.

Tasks/Duties:

The Delegation Agreement for each Physician Assistant shall include problems and procedures typically encountered in the practice of Gynecological and Preventive care, which the PA has been trained to handle, and shall not exceed the normal scope of problems and procedures dealt with by the supervising physician(s) and must be in accordance with the policies of PPNNE.

There follows a list of tasks allowed to be included in the PA's Delegation Agreement which is intended to express a sense of involvement in the medical care and not intended to be a limiting one, except as specifically excluded by the Board of Medical Practice or by law. Participation in the practice of PPNNE's health centers shall include the performance of the following tasks:

A. Provide information and counseling on: family planning methods; sterilization; pregnancy; adoption; abortion; common gynecological problems; sexually transmitted diseases; sexual assault; male reproductive health; infertility; midlife health; general preventive health care.
B. Order and dispense hormonal contraceptives and HT/ET in accordance with PPNNE Medical Protocol.
   Manage routine hormonal contraceptive and HT/ET problems.
   Order special laboratory tests needed to prescribe hormonal contraceptives and HRT.
C. Insert and remove implant contraceptive systems in accordance with the PPNNE Medical Protocol.
   Manage routine implant system problems.
D. Inject Medroxyprogesterone acetate in accordance with PPNNE Medical Protocol.

Planned Parenthood
of Northern New England

Physician Assistant Delegation Agreement

Manage routine DMPA problems.

E. Insert and remove IUD's in accordance with the PPNNE Medical Protocol.
Manage routine IUD problems.
Order X-rays and sonograms for IUD localization.

F. Fit and check diaphragms, cervical caps and other barrier devices in accordance with PPNNE Medical Protocol.
Manage diaphragm, cervical cap and other barrier device problems.

G. Order and dispense condoms and vaginal spermicides in accordance with the PPNNE Medical Protocol.
Manage condom and spermicide problems.

H. Counsel and provide continuing evaluation and support of the natural methods of birth control: BBT, symptom-thermal, cervical mucus and calendar.

I. Evaluate patient history, perform elementary physical examination and pelvic examination, order and evaluate laboratory and other tests indicated and administer immunizations and other medications in accordance with the PPNNE Medical Protocol.

J. Order, administer and/or dispense medications in accordance with the PPNNE Medical Protocol and state and federal laws.

K. Diagnose and order or dispense treatment for conditions covered in the PPNNE Medical Protocol as indicated in the protocol.

L. Perform pregnancy diagnosis as per the PPNNE Medical Protocol. Order serum HCG pregnancy test, and sonograms.

M. Provide services to patient in the abortion, cervical dysplasia, infertility, male services and midlife programs as per the PPNNE Medical Protocol and Medical Protocol Supplements.

N. Provide routine gynecologic and general preventive health care as per the PPNNE Medical Protocol. Manage and follow-up routine and problem patients in accordance with the PPNNE Medical Protocol.

O. Perform venipuncture; start and maintain I.V.'s.

P. Order and follow-up on outside laboratory tests and dispense treatment for conditions not specifically covered in the PPNNE Medical Protocol under the direct guidance of a PPNNE physician with the Medical Director's approval.

Q. Pursuant to delegation from the Medical Director, to provide reproductive health care to minors, including and especially contraception and diagnosis and treatment of sexually transmitted infections, as indicated with or without parental consent if the minor may suffer probable health hazards if such services are not provided.

R. Where permissible by law, provide abortion services in accordance with the PPNNE Medical Protocol.

S. Authorization to prescribe medications.

1. The physician assistant named in this document will be authorized to prescribe medications in accordance with the Delegation Agreement submitted to and approved by the Vermont Board of Medical Practice.
2. The physician assistant named in this document will be authorized to prescribe controlled drugs in accordance with the Delegation Agreement and approved by the Vermont Board of Medical Practice. A physician assistant who prescribes controlled drugs must obtain an identification number from the federal Drug Enforcement Agency (DEA).

MH1787956
PA's VT DEA Number

I have reviewed the above and acknowledge that these proposed activities do not exceed the scope of my current practice within Planned Parenthood of Northern New England, and that I will act as a principal supervising physician for the physician assistant named below, in their practice within this scope.

Anna Hildreth PA	Anne Sorensen Hilda	1/10/14
Print Name	Signature	Date
Donna Burkett, MD	D Burkett	1-9-14
Collaborating Physician/Medical Director	Signature	Date

nccpa
Certification. Excellence.

January 13, 2014

ATTENTION: Tracy Hayes

To Whom It May Concern:

The following score report for Anne Sarver Hildreth is provided for your information.

Exam: Physician Assistant National Recertifying Examination (PANRE)
Exam Date: December 18, 2013
Score: 434
Minimum Passing Score: 379
Pass/Fail Status: Pass

Anne Sarver Hildreth is currently certified by NCCPA and holds NCCPA identification number 1011311.

NCCPA identification number 1011311 will remain valid until December 31, 2015. This PA was initially certified on January 15, 1983. However, this PA may or may not have been continuously certified during this time frame.

Should you have any questions regarding the information provided in this report, please contact us at the number below. To receive information about NCCPA's certification requirements and policies, visit our Web site at www.nccpa.net or call 678.417.8100 to speak with one of our Information Service Representatives.

Sincerely,

Cindy Nalls

Cindy Nalls
Manager of Certification Maintenance

P.S. You can verify the certification status of a PA by visiting our Web site at ww.nccpa.net.

The original version of this document includes NCCPA's raised seal, affixed above.

National Commission on Certification of Physician Assistants
12000 Findley Rd., Ste. 100, Johns Creek, GA 30097 • Tel: 678.417.8100 • Fax: 678.417.8135 • www.nccpa.net

MY RECORD

Close Window

2011-2013

Anne Hildrath, your certification number 1011311 expires on 12/31/2015.

2011-2013 | All | Go

Cycle	Credits	Category	Date	Program Title	Provider	Sponsor	View
2011-2013	7.00	I	04/29/2013 - 04/30/2013	NAF conference. 37th annual meeting	American Academy of Family Physicians	AAFP	
2011-2013	11.75	I	08/05/2012 - 08/07/2012	National Reproductive Health conference - Title X	University of Missouri-Kansas City School of Medicine	AMA	
2011-2013	6.00	I	06/19/2012	Planned Parenthood Abortioin in - service	University of Vermont College of Medicine	AMA	
2011-2013	16.50	I	06/11/2013 - 06/14/2013	Family medicine review course	University of Vermont College of Medicine	AMA	
2011-2013	3.50	I	04/27/2013	NAF , clinicians for choice.	American Academy of Family Physicians	AAFP	
2011-2013	13.00	I	05/09/2012 - 05/11/2012	Womens health Conference	University of Vermont College of Medicine	AMA	
2011-2013	200.00	II	06/10/2013 - 07/12/2013	Clinical Preceptor for PA students at Franklin Pierce university			

Total Credits: 257.75

When logging these credits, I certified that the information contained above is true and correct. I also acknowledged that it is my responsibility to provide valid supporting documentation for all of my Category I credits if requested.

Printing Tip: Adjust browser page setup to landscape to print this report.