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

80
5008

2008 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

License Number: 042-0011506

1. **Your legal name:**

   Rebecca Keene Jones

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

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

   ____
   Last Name First Name Middle Name: Suffix

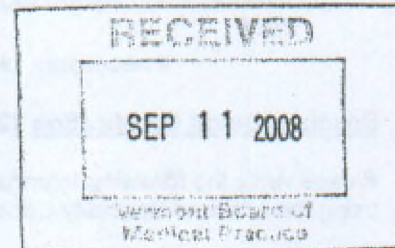
   b. Indicate your name, as it should appear on your license:

   ____
   Last Name First Name Middle Name: Suffix

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

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

   204 Maple Grove Road
   MOHNTON, PA 19540
   pineytop@msn.com



4. **Work Address:**
   204 Maple Grove Road
   MOHNTON, PA 19540
   pineytop@msn.com

5. **Please check your preferred mailing address:** ___ **Home** _X_ **Work**
   NOTE: ***The mailing address will be publicly listed on the Board's web site.***

6. **Home Telephone Number with Area Code:** ([redacted]

7. **Work Telephone Number with Area Code:** (610) 334-0098

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

____

Please check here if the Department of Health may use this e-mail address to send you public health information.
□ yes X no

PART II

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

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

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

State	License Number	Type of License	Date Issued	Status (Active, Inactive, or other, conditioned, restricted, limited)
PA		Unrestricted ↓		Active ↓
NM 2005				
MA				
WV				
WA				

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

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

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

University of Pennsylvania, PHILADELPHIA, PA
5/21/1991

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

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

Reading Hospital ,PA
Obstetrics and Gynecology
1995

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

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

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

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

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

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

Month and year you started practicing as a physician? Jul-95

15. **Hospital Privileges** [26 VSA § 1368(a)(11)] ☐ Check here if none

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

Yakima Valley Memorial Hospital
Yakima, WA
(2006-)
Obstetrics and Gynecology

Reading Hospital
Reading, PA
(2007-)
Obstetrics and Gynecology

~~Caritas Norwood Hospital~~
~~Norwood, MA~~
~~(2006-)~~
~~Obstetrics and Gynecology~~

~~Weirton Medical C~~

Gifford Medical Center
Randolph, VT
2008-
Obstetrics and Gynecology

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

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

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

□ yes ☒ no

PART III

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

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

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

[redacted]

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

[redacted]

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

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

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

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

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

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

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

CONFIDENTIAL ASSISTANCE IS AVAILABLE

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

PART IV

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

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

32. **Criminal Convictions** [26 VSA § 1368(a)(1)] X Check here if none

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

None reported

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

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

None reported

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

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

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

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states, if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

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

A. **Revocation/Involuntary Restrictions** X Check here if none

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

B. **Other Restrictions** X Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital if not listed below. **Please provide complete copies of documentation for each matter.**

None reported

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

A. **Judgments** X Check here if none

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

None reported

B. **Settlements** X Check here if none

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

None reported

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

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

A. Appointments ☒ Check here if none

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

None reported

B. Teaching ☒ Check here if none

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

None reported

39. **Publications**: [26 VSA § 1368(a)(13)] ☒ Check here if none

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

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

40. **Activities** [26 VSA § 1368(a)(14)] ☒ Check here if none

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

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

None reported

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

What is the location of your primary practice setting?

42. **Translating Services** [26 VSA § 1368(a)(16)] ☒ Check here if none

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

If yes, please describe here the translating services available:

None

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

A. **Medicaid participation**

Do you participate in the Medicaid program? ☒ yes ☐ no

B. **New Medicaid Patients**

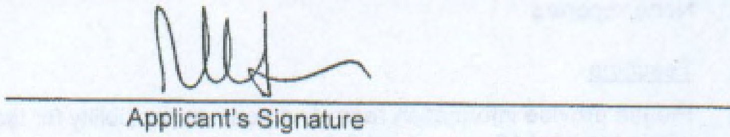
Are you currently accepting new Medicaid patients? ☒ yes ☐ no

Part V

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

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

Date: 9/9/08



Applicant's Signature

Physician Profile Update

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

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

OMIT FROM PROFILE

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

Again, thank you for your cooperation.

Vermont Department of Health - Board of Medical Practice

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

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

- [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 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:

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

or

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

Regarding Unemployment Compensation Contributions

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

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

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

or

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant [signature] Date 9/9/08

PHOTOGRAPH

Part VII - Signature

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

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: 11/8/07 [signature]

Applicant's Signature

Return completed application to: **VERMONT DEPARTMENT OF HEALTH**
BOARD OF MEDICAL PRACTICE
108 Cherry Street, P0 Box 70
Burlington VT 05402-0070

State of Vermont

Department of Health

Board of Medical Practice

Statement of Good Standing

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

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

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

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

(1) 60 days or fewer have elapsed since the date a judgment was issued; or

(2) the person is in compliance with a repayment plan approved by the judiciary.

Date: 9/9/06

PLEASE NOTE:

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

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

[phone] 802-657-4220
[toll free] 800-745-7371
[tty] 802-657-4227

Agency of Human Services

January 3, 2008

Rebecca Jones MD
204 Maple Grove Road
Mohnton, PA 19540

Re: Vermont Medical Licensure - 042-0011506

Dear Dr. Jones:

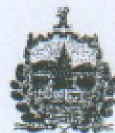
Congratulations on receiving a license to practice medicine in Vermont. On January 2, 2008, the Vermont Board of Medical Practice granted you a Vermont medical license. Please note above. Enclosed please find your physician license and information relevant to practice in Vermont. A wall certificate is being processed and will be sent to you under separate cover.

All medical licenses are renewed in November of every even year. You will receive a notification three months prior to the renewal date. Until that time, *licensees have a continuing obligation to promptly notify the Board of any change or new information including, but not limited to, change of address, 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.*

If you have any questions or need additional information please do not hesitate to contact the Board.

Sincerely,

Tracy Hayes
Administrative Assistant
Board of Medical Practice



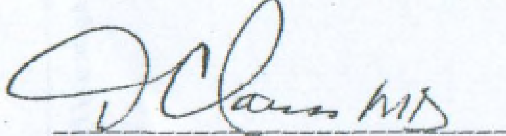
State of Vermont
Board of Medical Practice

THIS IS TO CERTIFY

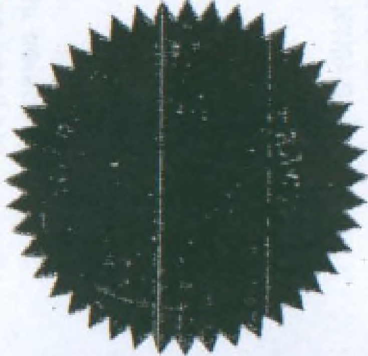
Rebecca Keene Jones, MD

a graduate of The University of Pennsylvania, 1991

having successfully qualified as a practitioner of medicine before this Board has been registered as provided by the Laws of the State.



Chair: David W. Clauss, MD



Secretary: Margaret F. Martin

Burlington
Date: January 2, 2008
Received and duly recorded.
Vermont Department of Health

License Number 042-0011506

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

[phone] 802-657-4220
[toll free] 800-745-7371
[tty] 802-657-4227

Agency of Human Services

December 10, 2007

Rebecca Jones MD
204 Maple Grove Road
Mohnton, PA 19540

Dear Dr. Jones:

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

John J Murray, M.D.
PO Box 607
Colchester, VT 05446
(802) 865-9390

You must complete your interview within six months from the date of this letter or your application will be considered stale. This means that you will have to update the following: License verifications from other states; three letters of recommendation, National Practitioners Data Bank Self Query, and the AMA Profile.

The full Board will act upon your request for licensure at the next scheduled Board meeting following your interview.

Should you have questions or concerns, please feel free to contact me at 802-657-4223.

Sincerely,

Tracy

Tracy Hayes
Administrative Assistant
Board of Medical Practice

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

[phone] 802-657-4220
[toll free] 800-745-7371
[tty] 802-657-4227

Agency of Human Services

12/10/2007

John Murray, MD
PO Box 607
Colchester, VT 05446

Dear Dr. Murray:

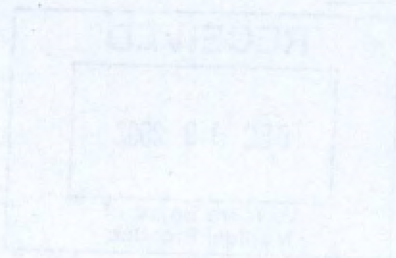
The application for medical licensure for **Rebecca Jones MD** is complete, and is enclosed for your review. The applicant will be calling you to schedule a personal interview. Following the interview, you may present the application at the first, regularly scheduled Board meeting.

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

Sincerely,

Tracy Hayes
Administrative Assistant
Board of Medical Practice

Enclosures



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

Information Related to Video Interviews

If you wish to conduct your personal interview via interactive television to save the time and expense of traveling to Vermont, please make the appropriate arrangements, sign the following release form, and return it to this office prior to the start of the interview. If you choose this option, we will make every effort to cooperate, but you must bear the expense. If you need further information or assistance please contact the Board office at (802) 657-4220.

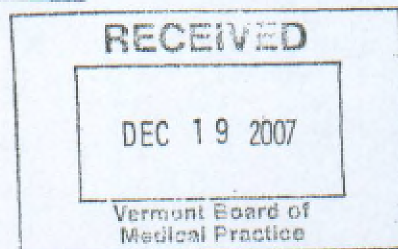
Release

I hereby request the opportunity to participate in a video conference interview with a member of the Vermont Board of Medical Practice. This interview is part of my application process for obtaining a physician's license in Vermont. I understand that Vermont law requires this personal interview before a license can be issued by the Board, but that such interviews are usually conducted in Vermont, with both parties in the same location, and that the use of video conferencing technology is in no way required for licensure by the Board. I also understand that the use of video conferencing technology will necessarily allow one or more other parties to observe and listen to portions of the interview. I request the use of this technology as an accommodation to me, to save me the time and expense of traveling to Vermont. I hereby expressly waive any rights of confidentially I have with respect to the conduct of this interview, provided, however, that I may, at any time during the interview and without penalty, elect to stop the interview, and that I will have the right to continue the interview at a later date, in Vermont, in a confidential setting in which both the Board interviewer and I will be present.

Date: 12/17/07

Printed Name: Rebecca Jones

Signature: ____________



V1 d00

Medical Doctor Application Checklist
For Office Use Only
STATE OF VERMONT - BOARD OF MEDICAL PRACTICE

Name of Applicant: Rebecca Veere Jones

Address: 204 Maple Grove Rd
Mohnton, PA 19540

Telephone: 610-334-0098

Date Application Received: 11/2010

____US Graduate ____Canadian Graduate ____International Graduate

(Unless noted, a copy of original, and English translation if applicable, is requiredto be submitted):

1) X **FEE of $565.00**

2) X **COMPLETED APPLICATION** for License to Practice Medicine in Vermont.
   - X **Photograph Applicant's signature required on photograph.**
   - X **Tax & Child Support Statement Applicant's signature required.** [redacted]
   - X **Form B: Release Applicant's signature required.**

*3) X **BIRTH CERTIFICATE - Notarized**
Date of Birth [redacted]

*4) X **MEDICAL SCHOOL DIPLOMA – Notarized**
Univ of Pennsylvania Date: 5/21/91

*5) X **MEDICAL EDUCATION CERTIFICATE- Direct Verification**

6) X **MEDICAL LICENSURE CERTIFICATE - Direct Verification**
☐ All in good standing

X	PA	X	WV
X	NH	X	WA
X	MA		

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

____USMLE** ____FLEX X National Boards ____State Exam ____LMCC

____Number of times applicant has taken USMLE Step 3 (can be no more than 3 times).
____Number of years applicant has taken to complete (can be no more than 7 times)

8) X **AMERICAN SPECIALTY BOARD CERTIFICATE, if applicable - Notarized**
OB/GYN (BC)

*9) X POSTGRADUATE TRAINING from an ACGME approved residency program - Direct Verification. VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION must be completed by Program Director.

Reading Hospital DATES 1995 ACGME ____

____ DATES ____ ACGME ____

____ DATES ____ ACGME ____

____ DATES ____ ACGME ____

____ DATES ____ ACGME ____

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

X #1 Chief of Service George Pevlert

or ____ Program Director ____

X #2 Active Physician Staff Member John Snider

X #3 Active Physician Staff Member Lorraine Balle

11) X American Medical Association Profile Form.
- ☒ Verify information provided on application

*12) N/A ECFMG Certificate, if International Graduate. ____ Verification of Fifth Pathway
- ☐ Passed/Approved

13) X National Practitioners Data Bank self-query: Applicant sends the original, unaltered response to the Board.
- ☒ Has applicant included everything on the application

14) N/A FORM A if applicant answered Yes in Section III—Refer to licensing Committee

15) X CV/Resume

16) ____ FEDERATION CHECK
- ☐ Check for board actions

* NOTE: FCVS Acceptance - The Board accepts certain documents noted by asterisks (*) above.

S:\MEDFORMS\MDCHEKL.WPD

V1 d00

Medical Doctor Application Checklist

For Office Use Only

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE

Name of Applicant: Rebecca Keene Jones

Address: 204 Maple Grove Rd

Mohnton, PA 19540

Telephone: 610-334-0098

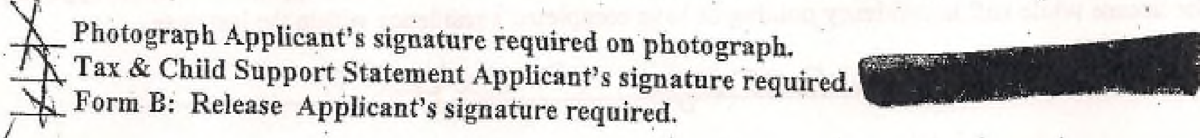
Date Application Received: 11/20/07

___US Graduate ___Canadian Graduate ___International Graduate

(Unless noted, a copy of original, and English translation if applicable, is requiredto be submitted):

1) X FEE of $565.00

2) X COMPLETED APPLICATION for License to Practice Medicine in Vermont.

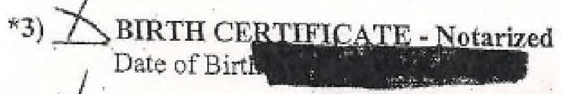


X Photograph Applicant's signature required on photograph.

X Tax & Child Support Statement Applicant's signature required.

X Form B: Release Applicant's signature required.

*3) X BIRTH CERTIFICATE - Notarized



Date of Birth

*4) X MEDICAL SCHOOL DIPLOMA – Notarized

Univ of Pennsylvania Date: 5/21/91

*5) X MEDICAL EDUCATION CERTIFICATE- Direct Verification

6) X MEDICAL LICENSURE CERTIFICATE - Direct Verification

☐ All in good standing

X PA X WV

X NM X WA

X MA

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

___USMLE** ___FLEX X National Boards ___State Exam ___LMCC

___Number of times applicant has taken USMLE Step 3 (can be no more than 3 times).

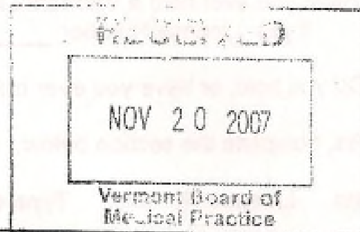
___Number of years applicant has taken to complete (can be no more than 7 times)

8) X AMERICAN SPECIALTY BOARD CERTIFICATE, if applicable - Notarized

X OB/GYN (BC)

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

APPLICATION FOR LICENSE TO PRACTICE MEDICINE IN VERMONT PHYSICIAN – MEDICAL DOCTOR



I hereby apply for LICENSURE AS A PHYSICIAN in the state of Vermont.

Part I - Identity Questions

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

JONES REBECCA KEENE

Last Name First Name Middle Name Suffix

2. Have you ever legally changed your name? __ Yes X No
If yes, enclose a certified copy of the legal document stating the change.

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

Last Name First Name Middle Name Suffix

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

4: Your mailing address: (Check one: ☑ home address ☐ work address)

Care of:

Street: 204 Maple Grove Rd

Town/City: Mohnton

State: PA

Zip: 19540

5. Your contact information:

Home telephone number with area code: [redacted]

Work telephone number with area code: (610) 334-0098

E-mail Address: pineytop@msn.com

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

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

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

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

July 1995

8. Have you ever held a Vermont Limited Temporary License: ___Yes _X_ No
If yes, License Number ______________________

9. Do you hold, or have you ever held, a medical license in any other state? _X_ Yes ___No

If yes, complete the section below:

State	License Number	Type of License	Date Issued	Status(Active or Inactive)
PA	MD051312L	MD	exp 12/31/08	Active
NM	MD 2005-0829	MD	12/8/05 exp 7/1/09	Active
MA	#227062	MD	exp 11/17/08	Active

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

Part II – Education, Training, Practice and Examinations

10. Premedical Education

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

Name and location of institution	Degree	From	To
Boston University	BA	9/73	5/77

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

11. Medical Professional Schools – See enclosed form

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

University of Pennsylvania Phila PA 1991
(School/institution) (City) (State) (Year of Graduation)

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

12. Graduate Medical Education – See enclosed form
Please provide the names of graduate medical schools you attended and the dates of attendance.

Jones, Rebecca K

Page 2 (cont) Education

- University of Edinburgh — 1977-1979
  Edinburgh, Scotland, UK — M.Phil
- Institute of Child Development — 1979-1982
  University of Minnesota — Ph.D.
  Minneapolis MN
- Drexel University — 1984-1986
  Philadelphia PA — Post-baccalaureate pre-med studies

Rebecca K. Jones

Reading Hospital	OB/GYN	Reading	PA	1995
(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation)
(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation)
(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation)

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

13. Specialty Board Certification

Enter up to three specialty codes from the enclosed ***Specialty Codes List***. List your primary specialty first. If you cannot locate a specialty, please write the specialty name in the space provided.

Specialty Code				Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
1	1	0	1	OB/GYN	☒ yes ☐ no	ABOG	1997	2007
					☐ yes ☐ no			
					☐ yes ☐ no			

14. Examinations

USMLE____ FLEX____ National Board X LMCC____

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

15. International Medical Graduates

A. ECFMG Standard Certificate Number: N/A Date issued: ________

B. Direct verification of your ECFMG Certificate must accompany this application. (See enclosed request form)

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

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

16. Practice

Do you have hospital privileges? X Yes _____ No

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

Name	Address	From/To	Specialty/Subspecialty

Rebecca K. Jones

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16. Practice - All hospitals with privileges

Current: Yakima Valley Memorial Hospital
2811 Tieton Dr.
Yakima, WA 98902
active 9/06 to present OB/GYN

- Reading Hospital and Medical Center
PO Box 16052
Reading, PA 19612
1995-2005 active
2007 - locum tenens OB/GYN

- Caritas Norwood Hospital
800 Washington St
Norwood, MA 02062
2006 - locum tenens OB/GYN

- Weirton Medical Center
651 Collier Way
Weirton, WV 26062
2006 - locum tenens OB/GYN

- Brandywine Hospital
201 Reeceville Rd
Coatesville, PA 19320
OB/GYN
2005 - locum tenens

Rebecca K. Jones

See list

Part III - Licensure and Practice Questions

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

17. Have you ever applied for and been denied a license to practice medicine or any other healing art?
___Yes X No

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

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

20. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
___Yes X No

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

22. Have you ever discontinued your education, training, or practice for a period of more than three months, for reasons other than a family situation?
___Yes X No

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

24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?
___Yes X No

25. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
___Yes X No

26. Are you presently a defendant in a criminal proceeding?
___Yes X No

Part IV - Confidential Section

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Rebecca K Jones

Part III is exempt from public disclosure

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

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

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

MEDICAL QUESTIONS

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

DEFINITIONS

In answering the questions above, please use these definitions:

"Ability to practice medicine" - This term includes:

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

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

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

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

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

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

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

S

Rebecca K Jones

[redacted]

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

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

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

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

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

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

Part V - Statutory Profile Questions

Vermont law, 26 VSA § 1368, creates a data repository within the Department of Health. Under this law, the Department must collect certain information to create individual profiles on all health care professionals licensed, certified, or registered by the Department pursuant to Title 26 of the VSA. Please try to answer the following questions as best as you can. You will receive a copy of your profile prior to its initial release to the public and each time the profile is modified or amended. You will be given a reasonable time to correct factual inaccuracies that appear in such profile. As noted below, certain questions do not need to be answered.

It is very important for us to receive photostatic copies of court papers, licensing authority decisions, and other documents relevant to the questions below in order to have a true and accurate description of the actions taken.

32. <u>**Criminal Convictions**</u> [See 26 VSA § 1368(a)(1)]

Rebecca K Jones

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

NONE

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

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

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

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.

NONE

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

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

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

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

NONE

(Date) (Final Disposition – Summary)

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

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

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

NONE

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

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

Rebecca K Jones

36. **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.

NONE

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

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

B. **Other Restrictions**

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

NONE

(Date) (Hospital) (State)

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

□ In Lieu □ In Settlement

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

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

A. **Judgments**

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

□ Judgment □ Arbitration

NONE

Rebecca K Jones

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

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

B. Settlements

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

NONE

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

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

38. **Appointments/Teaching** [See 26 VSA § 1368(a)(12)] Note: Answering #38 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

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

NONE

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

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

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

B. Teaching

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

NONE

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

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

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

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

Rebecca K Jones

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

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

(Title) (Publication) (Year)

(Title) (Publication) (Year)

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

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

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

(Activities or Awards)

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

- End of Statutory Profile Questions -

41. **Interview**

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

B. When are you scheduled to begin work in Vermont? Jan 2008

C. What has been your physical residence (city, state) in the past ten years?
204 Maple Grove Rd
Mohnton, PA 19540

Part VI - Photograph

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

Rebecca K Jones

PHOTOGRAPH

Part VII - Signature

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

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: 11/8/07 ____________________ Applicant's Signature

Return completed application to: **VERMONT DEPARTMENT OF HEALTH**
BOARD OF MEDICAL PRACTICE
108 Cherry Street, P0 Box 70
Burlington VT 05402-0070

Rebecca K. Jones, M.D., Ph.D., F.A.C.O.G.

204 Maple Grove Rd.
Mohnton, PA 19540

Date of Birth:
Birthplace: Pittsburgh, PA

Children:

Email: pineytop@msn.com

Objective: After ten years (1995-2005) in a busy and rewarding two person OB/GYN practice, I have been working locum tenens assignments full-time. I am open to most locations and prefer short to medium-length jobs (up to approximately four months). I am eager to live and work in a variety of communities while contributing to the health of women.

Education

1973-1977	Boston University Boston, MA	B.A., *summa cum laude* Psychology & Philosophy
1977-1979	University of Edinburgh Edinburgh, Scotland, UK	M.Phil. Experimental Psychology
1979-1982	Institute of Child Development University of Minnesota	Ph.D. Child Development
1984-1986	Drexel University Philadelphia, PA	Post-baccalaureate premed science studies
1986-1991	University of Pennsylvania Philadelphia, PA (study was interrupted one year for maternity leave)	M.D.

Employment

1982-1983	Department of Psychology Villanova University, PA	Lecturer
1983-1984	Eastern Women's Center New York, NY	Counselor
1988-1989	School of Medicine University of Pennsylvania	Instructor, Seminar on Child Development

Employment

1991-1995	Reading Hospital Reading, PA	Intern and Resident Obstetrics & Gynecology
1995-2005	Reading OB/GYN, PC Reading, PA	Physician

Locum Tenens Assignments

07/07-present	Yakima Valley Farrm Workers Yakima, WA	General obstetric and gyne- cological coverage
02/07-05/07	Reading Hospital Reading, PA	Supervised OB/GYN residents
09/06-01/07	Yakima Valley Farm Workers Yakima, WA	General obstetric and gyne- cological coverage
05/06-06/06	Weirton Medical Center Weirton, WV	General obstetric and gyne- cological coverage
02/06-04/06 07/06	Caritas Norwood Hospital Norwood, MA	General obstetric and gyne- cological coverage
11/05-01/06	Planned Parenthood of North- eastern Pennsylvania	General gynecologic services
10/05	Brandywine Hospital Coatesville, PA	General obstetric and gyne- cological coverage

Honors and Awards

Elected member *Phi Beta Kappa*, 1977
National Science Foundation Graduate Fellowship, 1977-1980
Janet M. Glasgow Award, American Medical Women's Association, 1989

Professional Organizations

Fellow, American College of Obstetricians and Gynecologists
Board Certified, American Board of Obstetricians and Gynecologists (Original certification 1997; Annual voluntary recertification through 2009)

State Licenses

PA MD 051312L; NM MD 2005-0829; MA 227062; WV 22200; WA 00045964

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 10/26/07

3F

FORM B

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

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

TO WHOM IT MAY CONCERN:

1) I, Rebecca K. Jones, HEREBY AUTHORIZE YOU to furnish to the
(Name of Applicant)

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

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

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

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

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

Signature: [signature]

Date: Nov. 5th, 2007

Print or Type Name: Rebecca K. Jones

Address: 204 Maple Grove Rd

City, State, Zip Code: Mohnton, PA 19540

Telephone Number: (610) 334-0098

Subscribed and sworn to before me, this 5th day of November 2007

Elizabeth AW Mareld
Notary Public

Affix Seal

My License Expires: Feb. 20, 2008

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

ELIZABETH A W MARELD
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
FEBRUARY 20, 2008

VNIVERSITAS PENNSYLVANIENSIS

OMNIBVS HAS LITTERAS LECTVRIS SALVTEM DICIT

Cum academiis antiquus mos sit scientiis litterisve humanioribus excultos titulo iusto condecorare nos igitur auctoritate Curatorum nobis commissa

REBECCA KEENE JONES

ob studia a Professoribus approbata ad gradum

MEDICINAE DOCTORIS

admisimus eique omnia iura honores privilegia ad hunc gradum pertinentia libenter concessimus Cuius rei testimonio nomina nostra die mensis Maii xxi Anno Salutis MCMXCI et Vniversitatis conditae CCLI Philadelphiae subscripsimus

Shelton Hackney
PRAESES

William N. Kelley
DECANVS

Barbara Ray Stevens
Sigilli Custos

COMMONWEALTH OF PENNSYLVANIA :

COUNTY OF BERKS :

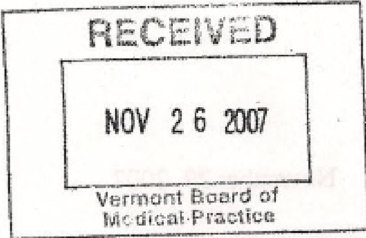
I CERTIFY THAT THIS COPY OF THE MEDICAL SCHOOL DIPLOMA OF REBECCA K JONES IS A TRUE, CORRECT AND COMPLETE COPY OF THE ORIGINAL.

IN WITNESS WHEREOF, I HEREUNTO SET MY HAND AND OFFICIAL SEALS. NOVEMBER 19TH , 2007.

Karen A. Bednar

Commonwealth of Pennsylvania
NOTARIAL SEAL
KAREN A. BEDNAR, Notary Public
Wyomissing Boro, Berks County
My Commission Expires June 27, 2011

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



CERTIFICATE OF MEDICAL EDUCATION

To be completed by an officer of your School of Medicine

I hereby certify that Rebecca K. Jones (Name) was admitted to the

University of Pennsylvania School of Medicine

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

and completed all requirements for graduation on 5/21/1991 (Date)

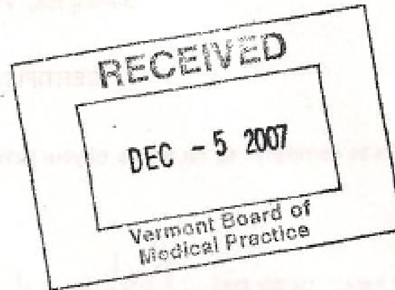
A M.D. (Specify certificate/diploma/degree) was granted on 5/21/1991 (Date)

(AFFIX SEAL)

Date: 11/14/07

Signed: [signature] 11/14/07
(Authorized Officer of the School)

STATE OF WASHINGTON
DEPARTMENT OF HEALTH



November 29, 2007

State of Vermont
108 cherry St
Burlington VT 05402

I, Betty Elliott, Program Representative, do hereby certify that a standard search of the available records of the Medical Quality Assurance Commission indicates the following:

PHYSICIAN'S NAME	**Rebecca Jones MD**
LICENSE NUMBER:	**MD00045964**
ISSUE DATE:	**01-05-2006**
EXPIRATION DATE	**11-17-2008**

ACCORDING TO OUR RECORDS, THIS LICENSE HAS NOT BEEN DISCIPLINED LICENSE IS ALSO IN GOOD STANDING

If our records above show that the licensee has been disciplined, photocopies from the public file are available upon written request. Send request to the Medical Quality Assurance Commission, Public Disclosure Desk, PO Box 47865, Olympia, WA 98504-7866 or may be obtained online at www.doh.wa.gov/medical.

The information above is the only certification information by the Commission. To expedite the certification process, the above format is the standard format prepared for all professions regulated by this Commission.

If you have any questions or need additional information, please contact me by telephone at (360) 236-4785, by email at betty.elliott@doh.wa.gov, or in writing at Department of Health, Medical Quality Assurance Commission, PO Box 47866, Olympia, Washington 98504-7866.

Sincerely,

Betty Elliott
Licensing Representative

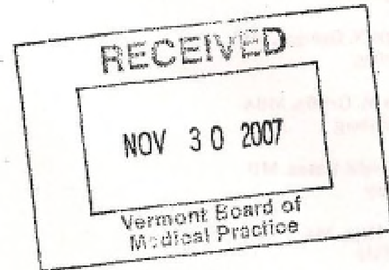
(SEAL)

4/12

0

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649
www.dos.state.pa.us

November 21, 2007



CERTIFICATION OF LICENSE

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	REBECCA KEENE JONES
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE NUMBER:	MD051312L
ORIGINAL LICENSURE DATE:	08/31/1993
EXPIRATION DATE:	12/31/2008
STATUS:	Active

The license is in good standing and the records indicate no derogatory information.

SEAL

Basil L. Merenda
Commissioner
Bureau of Professional and Occupational Affairs

Rev. Richard Bowyer
Fairmont

Michael L. Ferrebee, MD
Morgantown

Angelo N. Georges, MD
Wheeling

Doris M. Griffin, MBA
Martinsburg

M. Khalid Hasan, MD
Beckley

Beth Hays, MA
Bluefield

State of West Virginia

West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, WV 25311
Telephone (304) 558-2921
Fax (304) 558-2084

J. David Lynch, Jr., MD
Morgantown

Vettivelu Maheswaran, MD
Charles Town

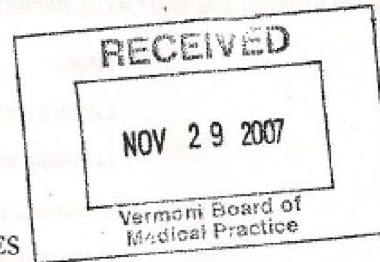
Bill May, DPM
Huntington

Leonard Simmons, DPM
Fairmont

Badshah J. Wazir, MD
South Charleston

Kenneth Dean Wright, PA-C
Huntington

VERIFICATION OF LICENSURE



Date: November 26, 2007

This is to verify that

REBECCA KEENE JONES

was issued license number 22200 on January 9, 2006 to practice as a Physician and Surgeon in the State of West Virginia.

She was licensed by National Boards.

Dr. Jones graduated from University of Pennsylvania School of Medicine on May 21, 1991.

The current licensure status is ACTIVE and expires on June 30, 2008.

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

Pennie Price
Pennie Price, Verification Coordinator

President
John A. Wade, Jr., MD
Point Pleasant

Vice President
Lee E. Smith, MD
Princeton

Secretary
Catherine Slemp, MD, MPH
Charleston

Executive Director
Robert C. Knittle
Charleston

Counsel
Deborah Lewis Rodecker
Charleston

Disciplinary Counsel
John K. McHugh
Charleston

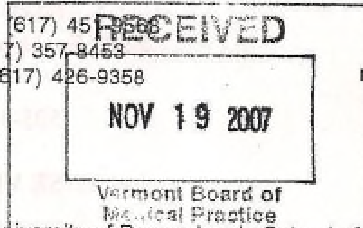
Commonwealth of Massachusetts
Board of Registration in Medicine

560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
Licensing Division Fax: (617) 426-9358



MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

11/14/2007

To Whom It May Concern:

This certifies that Rebecca K Jones M.D., a 1991 graduate of University of Pennsylvania School of Medicine, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 227062 was issued to Dr. Jones on 01/04/2006. This license is Current. The expiration date is 11/17/2008.

Listed below is certain complaint and disciplinary information on this physician. Please note that the Board can neither confirm nor deny the existence of open complaints.

Closed Complaint Information
Our files contain 0 closed complaint(s) on this physician.

Final Board Disciplinary Action
Our files contain 0 Board Discipline(s) to this physician.

This information is derived from Board files from January 1, 1987 to the present. It does not include all the information contained in a license application.

As a service to the public and to designated agencies, the Massachusetts Board of Registration in Medicine offers an online profile of all physicians with full licenses who are licensed in the Commonwealth. This profile is updated daily and may include public information that is not otherwise contained in this certification letter. You may access this information at the Board's website: www.massmedboard.org.

Finally, the Board tallies closed complaints separately from disciplinary actions. If the same underlying incident gives rise to both a complaint and a disciplinary action, the Board counts this as two separate actions. In the same way, multiple disciplinary actions are tallied separately, even if they arise from a single set of circumstances.

SEAL

Carrie Doyle
Staff Member, Board of Registration in Medicine
Carrie Doyle

New Mexico Medical Board
2055 S. Pacheco Street, Bldg. 400
Santa Fe, New Mexico 87505

505-476-7220

LICENSE VERIFICATION

Rebecca Keene Jones, M.D.
3611 Perkiomen Ave

Reading, PA 19606

Date of Birth: [redacted]

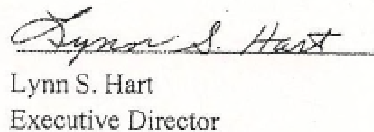
School Name	**Graduation Date**
Univ of Pennsylvania SOM	05/21/1991

Specialties
Obstetrics and Gynecology - BC

License #	**Issue Date**	**Expiration Date**	**Status**	**License Type**
MD2005-0829	12/08/2005	07/01/2009	Active	Medical Doctor

Our records indicate there is No Derogatory Information and the license is in good standing.

This license information was last updated on: 11/18/2007



Lynn S. Hart
Executive Director

Date: November 18, 2007

NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)

Endorsement of Certification

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9700

Recipient: Vermont Board of Medical Practice
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070

Date: 11/12/2007

Examinee ID: [redacted]
Examinee: Rebecca Keene Jones
Date of Birth: [redacted]

NBME Certification Date: 07/01/1992
Certificate#: 395321

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

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
					Individual Subject Scores						
09/07/1988	Pass	**Three-Digit**	420	(380)	370	455	485	440	365	385	555
		Two-Digit	76	(75)	72	78	80	77	72	73	84

NBME PART II

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Med	Surg	ObGyn	Prev	Peds	Psych
					Individual Subject Scores					
04/02/1991	Pass	**Three-Digit**	620	(290)	590	530	725	670	515	535
		Two-Digit	85	(75)	85	83	91	89	82	83

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)
03/04/1992	Pass	**Three-Digit**	600	(315)
		Two-Digit	85	(75)

1426/53205 VT

Patent 5636874
TouchSafe®

47

COMMONWEALTH OF PENNSYLVANIA :
SS.
COUNTY OF BERKS :

I CERTIFY THAT THIS COPY OF THE BOARD CERTIFICATE OF REBECCA K JONES IS A TRUE, CORRECT AND COMPLETE COPY OF THE ORIGINAL. IN WITNESS WHEREOF, I HEREUNTO SET MY HAND AND OFFICIAL SEALS.

NOVEMBER 19 2007

Commonwealth of Pennsylvania
NOTARIAL SEAL
KAREN A. BEDNAR, Notary Public
Wyomissing Boro, Berks County
My Commission Expires June 27, 2011

DIPLOMATE

American Board of Obstetrics and Gynecology

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

Obstetrics and Gynecology

Rebecca Keene Jones, M.D.

HAVING PURSUED AN ACCEPTED COURSE OF GRADUATE STUDY AND CLINICAL WORK, HAS MET THE STANDARDS AND QUALIFICATIONS, AND PASSED THE EXAMINATIONS REQUIRED BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC., AND IS AN ACKNOWLEDGED DIPLOMATE OF THE BOARD FROM NOVEMBER, 1997 THROUGH DECEMBER, 2007

NOVEMBER 7, 1997

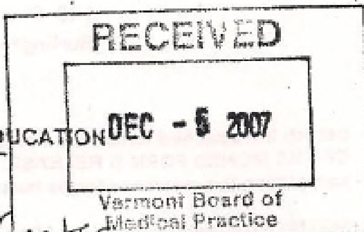
President

Executive Director

DIPLOMATE NO. 951172

48

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



VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

To be completed by the Training Program Director:

Name of Institution: Reading Hospital and Medical Center

Address: 56th Avenue + Spruce St.
West Reading, PA 19611

If name of the Institution was different when applicant attended, please enter name: N/A

I hereby certify that Rebecca K. Jones (Name) was enrolled in the

Residency
Program Type (residency, fellowship)

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

at this institution from June (Month) / 24 (Day) / 1991 (Year) to

June (Month) / 23 (Day) / 1995 (Year).

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

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

June (Month) / 23 (Day) / 1995 (Year).

(AFFIX SEAL)

Date: 11/30/07

Signed: [signature]
(Official of the Sponsoring Institution)

Print Name: A. GEORGE NEUBERT, M.D.

Title: CHAIR & PROGRAM DIRECTOR

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

LIST OF THREE REFERENCES

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

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

Names, addresses and telephone numbers of three references:

1) Reference #1 - Chief of Service (See Program Director Note * above): A. George Neubert MD

Address: Chair, Dept OB/GYN

Reading Hospital and Medical Center

City, State, Zip Code: Reading, PA

Telephone: (610) 988-8827

How long and in what capacity has this individual known you? 12 years; colleague and chair

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

Name: John Naiden MD

Address: Yakima Valley Women's Health Network

2205 W. Lincoln Ave

City, State, Zip Code: Yakima WA 98902

Telephone: (509) 575-1990

How long and in what capacity has this individual known you? 1 year; colleague and director

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

Name: Lorraine Bello MD

Address: 50 Union St #15

Northampton, I

City, State, Zip Code: Northampton, MA 01060

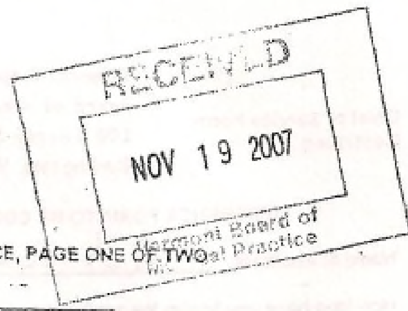
Telephone: (413) 695-1546

How long and in what capacity has this individual known you? 1 1/2 years; colleague

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

Chief of Service Form
Return Directly to Board

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



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

Name of Applicant: Rebecca K. Jones

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

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

Dr. JONES was at READING HOSPITAL

from 2/1/07 to 5/30/07. During that time, he/she was

(List status in the Institution): FACULTY ASSOCIATE PROVIDING RESIDENT TEACHING AND SUPERVISION

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.

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

Chief of Service Form
Continued

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

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

Name of Applicant: Rebecca K. Jones

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

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? 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 medicine? ___ 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? (Note: DWI (Driving While Intoxicated) is not minor.) ___ 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 problem (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:
- X Close personal observation
- ___ General impression
- ___ A composite of faculty/staff evaluations
- ___ Other - Specify: ______

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

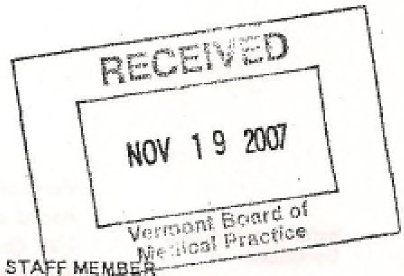
I recommend Dr. Rebecca Jones, M.D. for licensure in Vermont.
(Name of Physician)

Signed: [signature] Date: 11/12/07

Print or Type Name and Title: A. George Neubert, MD
Chair & Program Director

Reference Form #2
Return Directly to Board

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



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

Name of Applicant: Rebecca R. Jones

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

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

Dr. Rebecca Jones was at Yakima Valley Memorial Hospital

from 9/2006 to present. During that time, he/she was

(List status in the Institution): Locum tenens staff physician

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

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

Reference Form #2
Continued

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

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

Name of Applicant: Rebecca K. Jones

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

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

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

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

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

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

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

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

Does the applicant call upon consults when needed? ✓ Yes ___ No

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

The above report is based on:
- ✓ Close personal observation
- ___ General impression
- ___ A composite of faculty/staff evaluations
- ___ Other - Specify: ______

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

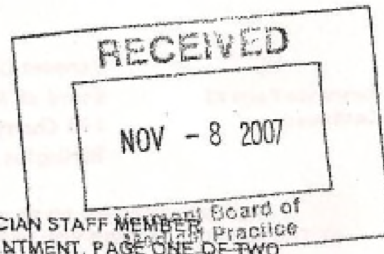
I recommend Rebecca Jones for licensure in Vermont.
Name of Physician

Signed: [signature] MD FACOG Date: 11/7/07

Print or Type Name and Title: John NAIDEN MD, FACOG

Reference Form #3
Return Directly to Board

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



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

Name of Applicant: Rebecca K. Jones

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

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

Dr. Rebecca K. Jones was at Caritas Norwood Hospital

from 1/2006 to 7/2006. During that time, he/she was

(List status in the institution): Locum tenens staff physician

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

Category	Poor	Fair	Average	Above Average
Basic medical knowledge:	___	___	___	✓
Professional judgment:	___	___	___	✓
Sense of responsibility:	___	___	___	✓
Moral character/ ethical conduct:	___	___	___	✓
Competence and skill:	___	___	___	✓
Cooperativeness, ability to work with others:	___	___	___	✓
History & physical exam taking:	___	___	___	✓
Record keeping	___	___	___	✓
Case presentations:	___	___	___	✓
Patient management:	___	___	___	✓
Physician-Patient relationship:	___	___	___	✓
Competence in being able to communicate in reading, writing and speaking the English language:	___	___	___	✓
Participation in Medical Staff Affairs	___	___	___	___ not applicable

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Reference Form #3
Continued

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

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

Name of Applicant: Rebecca K. Jones

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

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

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

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

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

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

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

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

Does the applicant call upon consults when needed? ✓ Yes ___ No

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

The above report is based on:
- ✓ Close personal observation
- ___ General impression
- ___ A composite of faculty/staff evaluations
- ___ Other - Specify: ___

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

I recommend Rebecca Jones, MD for licensure in Vermont.
Name of Physician

Signed: Lorraine K Bello, MD Date: 11/5/07 email: rainyb@comcast.net

Print or Type Name and Title: Lorraine K. Bello, MD OB-GYN

I worked closely with Dr. Jones, in the office and in the hospital, while we were both locum tenens physicians at Caritas Norwood Hospital. The patients, the nurses, and the office staff liked her very much and they all respected her medical care. She is competent, professional, and a genuinely good person.

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

BOARD ACTION CLEARANCE REPORT

December 07, 2007

Attn: John Howland Jr., Director
Vermont Board of Med. Practice
108 Cherry Street
PO Box 70
Burlington, VT 05401

Re: Board Action Query Dated: December 07, 2007
Your Reference Number:
FSMB Batch Number: BQ1417209

The following is a report of the search results from the Board Action Data Bank as of December 07, 2007 for practitioners sut above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of December 07, 2007

Item	Name	DOB	School	Yr/Grad
[redacted]		[redacted]	[redacted]	[redacted]
3	Jones, Rebecca	[redacted]	039050	1991
[redacted]		[redacted]	[redacted]	[redacted]

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

VITAL STATISTICS

CERTIFICATION OF BIRTH

DATE OF BIRTH (MO., DAY, YEAR, HOUR) [redacted] 7:29 a.m.

FILE NO. [redacted]

CITY, BOROUGH, OR TOWNSHIP OF BIRTH PITTSBURGH

DATE FILED (MO., DAY, YEAR) [redacted]

COUNTY OF BIRTH ALLEGHENY

DATE ISSUED (MO., DAY, YEAR) [redacted]

SUBJECT REBECCA KEENE JONES

SEX FEMALE

This is a true certification of name and birth facts on file in Vital Statistics, Pennsylvania Department of Health.

Charles Hardester
CHARLES HARDESTER
STATE REGISTRAR

H105.105 (Rev. 11-76)

Leonard Bachman
LEONARD BACHMAN, M.D.
SECRETARY OF HEALTH

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