STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE ONE OF SIX

I hereby apply for the renewal of my **LICENSE AS A PHYSICIAN** for the period from **12/01/92 to 11/30/94. TWO YEAR RENEWAL FEE: $205.**
Enclose a check in the amount of $205. made payable to the Vermont Board of Medical Practice.

42-0006920 A 10

Patricia T. Glowa MD

[redacted]

OCT 1992
VERMONT BOARD of Medical Practice

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Important:
- Please print legibly or type your answers.
- Answer all questions **(front and back of each page)** completely-it is not adequate to state that the Board already has the information. Use the **enclosed Form A** to provide explanations to "yes" answers in **Section II.**
- Make a copy of this form and all attachments for your own records.
- Do not delegate this important task to an employee, as false statements on this form are grounds for unprofessional conduct.
- **Thank you for your cooperation.**

SECTION I

1. Name: Patricia Todd Glowa MD 2. Vermont License Number: 42-_____

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

4. Home Address: [redacted]

City, State, Zip Code: [redacted]

5. Office Address: Dept. Family Medicine, UNC-Chapel Hill, C.B. 7595, Manning Drive

City, State, Zip Code: Chapel Hill, N.C. 27599-7595

6. Daytime Telephone Number: Area Code: (919) 966-3711

7. Date of Birth: Month: [redacted]

8. Place of Birth: [redacted] 9. Sex: ___ Male ✓ Female

10. Licensing Examination Taken - Check: ✓ National Boards _____ FLEX
_____ State Examination-identify State:_____ _____ Other Examination Specify:_____

11. Undergraduate Degree - Circle: (B.A.) B.S. A.B. Other: _____ Year of Graduation: 1973

Degree Granting Institution: City College of C.U.N.Y. Location: N.Y. N.Y.
First Institution (If transfer): McGill University Location: Montreal, P.Q. Canada

12. Medical Degree - Circle: (M.D.) Other:_____ Year of Graduation: 1977

Degree Granting Medical School: Harvard Location: Boston Mass

First Medical School (If transfer): ___ Location: _____

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13. Do you have hospital privileges **in Vermont**? _____ Yes ___✓___ No

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

14. Did you practice in Vermont during the past 12 months? ___✓___ Yes _____No

15. Other states where you now hold an active license to practice: N.C., N.Y.

16. States where you previously were licensed to practice: N.H.

17. Please list your specialty(ies) and indicate if you are American specialty board certified in those specialties:

Specialty(ies) & Subspecialty(ies)	American Specialty Board Certified (Yes or No)
(a) Family Practice	✓ Yes _____ No Year Certified/Recertified: 1980, 1986, 1992
(b)	_____ Yes _____ No Year Certified/Recertified: _____/_____
(c)	_____ Yes _____ No Year Certified/Recertified: _____/_____

18. Please list the postgraduate educational degrees that you have earned related to your practice:

Institution	City	State	Degree	Year
(a)				
(b)				

19. Please list the institutions where you have had residency or fellowship training:

Institution	City	State	Specialty	Year Completed
(a) Highland Hospital	Rochester	N.Y.	Family Medicine	1980
(b)				
(c)				

SECTION II: PLEASE CHECK YES OR NO.
A "YES" ANSWER REQUIRES AN EXPLANATION ON THE ENCLOSED FORM A.

1. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine, resident or fellow? [redacted]

2. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine, resident or fellow? [redacted]

3. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses? _____ YES ___✓___ NO

4. Are you currently under investigation for a criminal act? [redacted]

5. Are you now, or have you been in the past, dependent upon alcohol or drugs? [redacted]

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SECTION II CONTINUED

6. 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

7. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim/complaint/demand for damages)? [redacted]

8. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, resigned from a medical staff in lieu of disciplinary action or resigned from a medical staff after a complaint or peer review action has been initiated against you? ____ YES ✓ NO

9. Have you ever voluntarily surrendered or resigned a license to practice medicine or any healing art? ____ YES ✓ NO

10. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered by any jurisdiction or federal agency at any time? ____ YES ✓ NO

11. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill? ____ YES ✓ NO

12. Have you ever withdrawn an application for a medical license or been denied a medical license for any reason? ____ YES ✓ NO

13. Have you ever been turned down for coverage by a malpractice insurance carrier? ____ YES ✓ NO

14. Have you ever been notified as a responsible party of a Severity Level III quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? ____ YES ✓ NO

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

16. Have you ever been dismissed or asked to leave from a residency training program(s) before completion? ____ YES ✓ NO

SECTION III - TO BE COMPLETED ONLY BY PHYSICIANS PRACTICING IN VERMONT

1. Current Status (please check one): ✓ Active ____ Retired* ✓ Other (please explain) ____
***Note: If you are retired or are not practicing in Vermont, you need not complete SECTION III; however you must complete SECTION IV.** primary practice in N.C.; short-term practice annually at Stratton Mtn.

2. Postgraduate training in Vermont:
Are you currently in a postgraduate training program in Vermont as a resident or clinical fellow? ___ Yes ✓ No
If you are in a Vermont program, are you a ____ Resident ____Clinical Fellow ____ Research Fellow?
How many hours per typical week do you spend in this Vermont postgraduate training program? _____hrs./wk. in Vermont.

3. What is the date you started practicing medicine (excluding residency or fellowship training)?
(Month/Year) 8 / 80

4. What is the date you started practicing medicine **in Vermont** (excluding residency or fellowship training)?
(Month/Year) 8 / 83

5. Are you a **staff physician** involved **exclusively** in inpatient care or an emergency room setting? ___ Yes ✓ No

SECTION IV: STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
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A professional license or other authority to conduct a trade or business may not be renewed unless the licensee 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).

A professional license or other authority to conduct a trade or business may not be renewed unless the licensee certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship (32 V.S.A. § 3113). The maximum penalty for perjury is fifteen years in prison, a $10,000 fine, or both.

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT

✓ I hereby certify that I am not subject to any support order or I am subject to a support order and am in good standing with respect to or in full compliance with a plan to pay any and all child support due as of the date of this application.

OR

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

APPLICANT'S STATEMENT REGARDING TAXES

✓ I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a $10,000 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" to the address below.

STATEMENT OF APPLICANT

I further certify that all information contained in this renewal application (including all pages and attachments) is true and accurate to the best of my knowledge. *Failure to provide truthful and accurate information may constitute grounds for denial of license renewal or disciplinary action.*

Social Security Number: [redacted]

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

Date: 10/13/92 **Signature:** Patricia Todd Flores MD

Return the completed form and fee to: Vermont Board of Medical Practice
(Return envelope enclosed) 109 State Street
Montpelier, Vermont 05609-1106

QUESTIONS?: (802) 828-2673 - Toll Free (Within Vermont) 1-800-439-8683 (Ask for the Medical Board)

IMPORTANT: Please be sure to write your license number on your check. Check for the correct spelling of your name and proper address on the page one label. Print any changes in the adjoining space. Sign and date the application. Enclose the correct fee of $205.* in check or money order payable to the Vermont Board of Medical Practice.
(Medical Board Renewal Fee: $200. + Office of Professional Regulation (OPR) Fee: $5.00 = $205. OPR's $5.00 of the renewal fee represents an assessment for the Fee Limiting Subfund.)

***Note: Physicians 80 years of age or older are exempt from payment of a renewal fee; however the physician license renewal application must be completed and submitted.**

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SECTION III CONTINUED

Instructions for completing the next portion: Please complete one "site" section for each location where you practice. Be as detailed as possible. Estimate if exact figures are not available.

The codes to be used for the Employment Setting column are as follows (If applicable, list multiple codes at one practice site):

1 Solo Practice
2 Group Practice
3 Community Health Center
4 Hospital Outpatient Clinic
5 Hospital Inpatient
6 HMO (Health Maintenance Organization)
7 Extended Care Facility
8 School/College Health
9 Occupational Health
10 Emergency Room
11 Teaching
12 Other Specify: _____

6. Practice Site Number One

Street Address: _____

Town: _____ Zip: _____

Please complete **one full line for each specialty** (example: pediatrics) that you practice at this site.

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?

Check the financial organization which best describes this site: ____ For-profit ____ Nonprofit

If applicable, check the type of services that you perform at this site, even if the service is not practiced as a specialty:

____ Adult Medicine ____ Pediatric Medicine ____ Prenatal Care ____ Gynecologic Care

____ Obstetrics If you practice obstetrics, approximately how many deliveries do you perform per year at all practice sites? _____

(For example, a physician specializing in family practice who performs deliveries would check "Obstetrics".)

7. Practice Site Number Two

Street Address: _____ Town: _____ Zip: _____

Please complete **one full line for each specialty** that you practice at this site.

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?

Check the financial organization which best describes this site: ____ For-profit ____ Nonprofit

If applicable, check the type of services that you perform at this site, even if the service is not practiced as a specialty: ____ Adult Medicine ____ Pediatric Medicine ____ Prenatal Care ____ Gynecologic Care

____ Obstetrics If you practice obstetrics, approximately how many deliveries do you perform per year at all practice sites? _____

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SECTION III CONTINUED

8. Practice Site Number Three

Street Address: _____

Town: _____ Zip: _____

Please complete **one full line for each specialty** that you practice at this site.

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?

Check the financial organization which best describes this site: ____ For-profit ____ Nonprofit

Check the type of services that you perform at this site, even if the service is not practiced as a specialty:
____ Adult Medicine ____ Pediatric Medicine ____ Prenatal Care ____ Gynecologic Care
____ Obstetrics If you practice obstetrics, approximately how many deliveries do you perform per year at all practice sites? _____

9. Practice Site Number Four

Street Address: _____

Town: _____ Zip: _____

Please complete **one full line for each specialty** that you practice at this site.

Specialty	Hours per week engaged in direct patient care	Employment Setting (See codes on Page 4.)	Will the practice of this specialty be discontinued within the next 12 months? (Yes or No)	Will you accept new patients in this specialty? (Yes or No)	What percent of the patients in this specialty are funded by Medicaid? (Estimate if necessary.)	Will you accept new Medicaid patients in this specialty?	What percent of the patients in this specialty are funded by Medicare? (Estimate if necessary.)	Will you accept new Medicare patients in this specialty?

Check the financial organization which best describes this site: ____ For-profit ____ Nonprofit

Check the type of services that you perform at this site, even if the service is not practiced as a specialty:
____ Adult Medicine ____ Pediatric Medicine ____ Prenatal Care ____ Gynecologic Care
____ Obstetrics If you practice obstetrics, approximately how many deliveries do you perform per year at all practice sites? _____