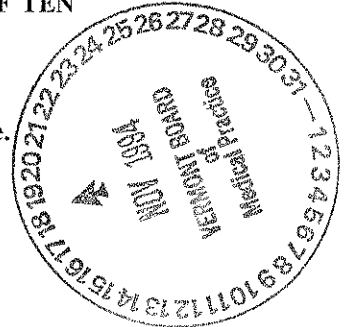


STATE OF VERMONT - BOARD OF MEDICAL PRACTICE  
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE ONE OF TEN

I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/94 to 11/30/96. TWO YEAR RENEWAL FEE: \$205.00.  
Enclose a check in the amount of \$205.00 made payable to the Vermont Board of Medical Practice.



Patricia T. Glowa



\*\*\*\*\*

**Important:**

- Please print legibly or type your answers.
- Answer all questions completely - it is not adequate to state that the Board already has the information. Use the enclosed Form A to provide explanations to "yes" answers in Section II.
- Make a copy of 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**

(Section I contains general information of interest to both the Board of Medical Practice and the Department of Health.)

1. Name: Glowa , Patricia T.
2. Vermont License Number: 42-6920
3. Other Name(s), if any, under which you were licensed in Vermont and elsewhere since your last renewal:

4. Home Address:

City, State, Zip Code:

5. Office Address: Univ. of North Carolina Dept. of Family Medicine  
Manning Dr., Chapel Hill NC 27599-7595

City, State, Zip Code: \_\_\_\_\_

**Note:** Circle either "Home Address" or "Office Address" as your preferred mailing address.

6. Daytime Telephone Number:

7. Date of Birth:

8. Place of Birth: \_\_\_\_\_

9. Sex (M/F): F

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE  
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF TEN

SECTION I CONTINUED

10. Licensing Examination Taken - Check:  National Boards  FLEX  State Examination-Identify State: \_\_\_\_\_  
 USMLE  Other Examination Specify: \_\_\_\_\_

11. Undergraduate Degree: (B.A., B.S., etc.): B.A. Year of Graduation: 1973

Major Course of Study: pre-med

Degree Granting Institution: City College of CUNY, N.Y.C., N.Y.

Location: New York, New York

First Institution (If transfer): McGill University

Location: Montreal, P.Q. Canada

12. Medical Degree: (M.D. or Other, please specify): M.D. Year of Graduation: 1977

Degree Granting Medical School: Harvard

Location: Boston, Mass.

First Medical School (If transfer): \_\_\_\_\_

Location: \_\_\_\_\_

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 hold an active license to practice: North Carolina, New York

16. States where you previously were licensed to practice: New Hampshire

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

Specialty Code(s) (See the list of specialty codes.)	American Board of Medical Specialties Certified (Yes or No)	Year Certified/Recertified
(a) <u>6 0 1</u>	<u>yes</u>	<u>1980 1986 1992</u>
(b) <u>— — — —</u>	<u>—</u>	<u>1</u>
(c) <u>— — — —</u>	<u>—</u>	<u>1</u>

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE  
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE THREE OF TEN

SECTION I CONTINUED

18. Please list the postgraduate educational degrees (MBA, MS, Ph.D., JD, etc.) that you have earned related to your practice:

(a) Postgraduate Degree: (Ph.D., etc.): \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Major Course of Study: \_\_\_\_\_

Degree Granting Institution: \_\_\_\_\_

Location: \_\_\_\_\_

(b) Postgraduate Degree: (Ph.D., etc.): \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Major Course of Study: \_\_\_\_\_

Degree Granting Institution: \_\_\_\_\_

Location: \_\_\_\_\_

(c) Postgraduate Degree: (Ph.D., etc.): \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Major Course of Study: \_\_\_\_\_

Degree Granting Institution: \_\_\_\_\_

Location: \_\_\_\_\_

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE  
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FOUR OF TEN

SECTION I CONTINUED

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

(a) Institution City State Country

Highland Hospital Rochester N.Y. USA

Specialty Code Year

(See attached list of specialty codes) Completed

601 1980

(b) Institution City State Country

Specialty Code Year

(See attached list of specialty codes) Completed

(a) Institution City State Country

Specialty Code Year

(See attached list of specialty codes) Completed

20. Are you a primary and/or secondary supervising physician for a physician's assistant (P.A.)?  Yes  No  
If yes, please list:

Name of P.A. Check if:

Frisch Payne Primary and/or Secondary

Ken Wolpert PA Secondary

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE  
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FIVE OF TEN

SECTION I CONTINUED

21. Are you now in a collaborative relationship with a nurse practitioner?  Yes  No  
If yes, please list the name(s) of the nurse practitioner(s):

Trish Payne CNM

Paul Dunn FNP

\_\_\_\_\_

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE  
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE SIX OF TEN

SECTION I CONTINUED

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STATE OF VERMONT - BOARD OF MEDICAL PRACTICE  
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE SEVEN OF TEN

SECTION II: PLEASE CHECK YES OR NO.

A "YES" ANSWER REQUIRES AN EXPLANATION ON THE ENCLOSED FORM A.

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

During the past two years:

- 1. Have you had any organic illness, 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 been a defendant in any criminal proceeding other than minor traffic offenses? \_\_\_ YES     NO
- 3. Are you currently under investigation for a criminal act? [REDACTED]
- 4. Have you been dependent upon alcohol or drugs? [REDACTED]
- 5. Are any formal disciplinary charges pending or has any disciplinary action 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
- 6. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim/complaint/demand for damages)? [REDACTED]
- 7. Have you 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
- 8. Have you voluntarily surrendered or resigned a license to practice medicine or any healing art in lieu of disciplinary action? \_\_\_ YES     NO
- 9. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered by any jurisdiction or federal agency at any time? \_\_\_ YES     NO
- 10. Have you been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill? \_\_\_ YES     NO
- 11. Have you withdrawn an application for a medical license or been denied a medical license for any reason? \_\_\_ YES     NO
- 12. Have you been turned down for coverage by a malpractice insurance carrier? \_\_\_ YES     NO
- 13. Have you been notified as a responsible party of a confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? \_\_\_ YES     NO
- 14. Have you been the subject of an investigation by any other licensing board? [REDACTED]

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE  
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE EIGHT OF TEN

SECTION II CONTINUED

15. Have you been dismissed or asked to leave a residency training program(s) before completion?    \_\_\_YES    NO

**IMPORTANT NOTE REGARDING THE QUESTIONS ABOVE AND ON THE PREVIOUS PAGE:**

Except for questions 1 and 4, "Yes" answers on past license renewals must be updated on Form A. For example, if a previously reported malpractice action has been dismissed, please indicate that on Form A. You have a continuing obligation to update the Board during the 1994-1996 period if the answer to any of the questions above changes from "No" to "Yes".



STATE OF VERMONT - BOARD OF MEDICAL PRACTICE  
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE NINE OF TEN

SECTION III

(Section III contains the assurances required by the Board of Medical Practice and is not part of the data base maintained by the Department of Health.)

**IMPORTANT:**

**WITHOUT EXCEPTION, ALL LICENSEES MUST COMPLETE (1), (2), (3) AND (4) BELOW OR THE LICENSE WILL NOT BE RENEWED. THANK YOU FOR YOUR COOPERATION.**

**(1) APPLICANT'S STATEMENT REGARDING CHILD SUPPORT (See Explanation Below)**

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

**(2) APPLICANT'S STATEMENT REGARDING TAXES (See Explanation Below)**

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.

**(3) SOCIAL SECURITY NUMBER:** 

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.

**(4) 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.

Date: 11/13/94 Signature: Patricia T. Glowa MD.

Return the completed form and fee to:  
(Return envelope enclosed)

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

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.

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 \$205.00\* in check or money order payable to the Vermont Board of Medical Practice. (Medical Board Renewal Fee: \$200.00 + Office of Professional Regulation (OPR) Fee: \$5.00 = \$205.00 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.

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE  
1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TEN OF TEN

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**VERMONT DEPARTMENT OF HEALTH SURVEY**

**SECTION IV**

**To be completed only by physicians practicing in Vermont.**

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV

(Section IV is especially for the needs of health care access planning/physician recruitment and retention efforts in Vermont.)

**\*Note:** If you are retired or are not practicing in Vermont, do not complete Section IV.

1. Current Status (please check one):  Active  Retired\*  Other (please explain) \_\_\_\_\_
2. Postgraduate training in Vermont:
  - (a) Are you currently in a postgraduate training program in Vermont as a resident or clinical fellow?  Yes  No
  - (b) Are you a  Resident  Clinical Fellow  Research Fellow?
  - (c) How many hours per typical week do you spend in this Vermont postgraduate training program?  
\_\_\_\_\_ hrs./wk. in Vermont.
  - (d) What is the medical school that you are affiliated with for this training?  
 University of Vermont  Dartmouth  Other (Please specify) \_\_\_\_\_
3. What is the date you started practicing medicine (excluding residency or fellowship training)?  
(Month/Year) \_\_\_\_\_ / \_\_\_\_\_
4. What is the date you started practicing medicine **in Vermont** (excluding residency or fellowship training)?  
(Month/Year) \_\_\_\_\_ / \_\_\_\_\_
5. Are you a **staff physician** involved **exclusively** in inpatient care or an emergency room setting?  Yes  No
6. What is your Unique Physician Identification Number (UPIN)? \_\_\_\_\_

**Instructions for completing this portion:** Please complete a WORK SITE section for each practice and location where you provide patient care. **For example**, if your patient care is distributed in the following manner, you would complete four WORK SITE sections, one for each combination of practice and site:

Practice	Site	WORK SITE Section in this form
Mountain Pediatrics	126 Cherry St., Burlington	NUMBER ONE
City Hospital	Pine St., Burlington	NUMBER TWO
Mountain Pediatrics	Route 116, Hinesburg	NUMBER THREE
Lakeview Pediatrics	Route 7, Vergennes	NUMBER FOUR

Be as detailed as possible. Estimate if exact figures are not available.

Be sure to include the patient care that you provide in an inpatient setting.

The codes to be used for the SPECIALTY column are enclosed on separate sheets.

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

7(a). WORK SITE: NUMBER ONE

Name of Practice(s): \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 Town: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is your practice at this site affiliated with an **IPA HMO**?  Yes  No  
 Is your practice at this site affiliated with a **Group/Staff HMO**?  Yes  No  
 Do you engage in **teaching** at this site?  Yes  No  
 Do you engage in **research** at this site?  Yes  No

Is your **personal** income from this practice site based on (check as many as apply):  
 Salary  Fee for service  Capitation  Cost based  Other (please specify) \_\_\_\_\_

The codes to be used for the PRACTICE SETTING column are as follows:

1 Solo Practice	7 Hospital Owned/Operated Office Practice
2 Group Practice: Single Specialty	8 Hospital Emergency Room
3 Group Practice: Multi-Specialty	9 Hospital Outpatient Clinic
4 FQHC/RHC Community Health Center	10 Hospital Inpatient
5 School or College Health Center	11 Extended Care Facility
6 Business or Worksite	12 Other: Specify _____

Please complete one full line for each SPECIALTY that YOU practice at this site.

SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new <b>Medicaid</b> patients in this specialty? YES or NO	Will you accept new <b>Medicare</b> patients in this specialty? YES or NO

Check the types of **primary care** services that you perform at this site, and the average hours per week of patient care, even if the service is not practiced as a specialty:

Service	Hours
General pediatric medical care	
General adolescent medical Care	
General adult medical care	
General geriatric medical care	
General gynecological medical care	
General obstetric medical care	

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

7(b). WORK SITE: NUMBER TWO

Name of Practice(s): \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 Town: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is your practice at this site affiliated with an **IPA HMO**? \_\_\_Yes \_\_\_No  
 Is your practice at this site affiliated with a **Group/Staff HMO**? \_\_\_Yes \_\_\_No  
 Do you engage in **teaching** at this site? \_\_\_Yes \_\_\_No  
 Do you engage in **research** at this site? \_\_\_Yes \_\_\_No

Is your **personal** income from this practice site based on (check as many as apply):  
 \_\_\_Salary \_\_\_Fee for service \_\_\_Capitation \_\_\_Cost based \_\_\_Other (please specify)\_\_\_\_\_

The codes to be used for the PRACTICE SETTING column are as follows:

1 Solo Practice	7 Hospital Owned/Operated Office Practice
2 Group Practice: Single Specialty	8 Hospital Emergency Room
3 Group Practice: Multi-Specialty	9 Hospital Outpatient Clinic
4 FQHC/RHC Community Health Center	10 Hospital Inpatient
5 School or College Health Center	11 Extended Care Facility
6 Business or Worksite	12 Other: Specify _____

Please complete one full line for each SPECIALTY that YOU practice at this site.

SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new <b>Medicaid</b> patients in this specialty? YES or NO	Will you accept new <b>Medicare</b> patients in this specialty? YES or NO

Check the types of **primary care** services that you perform at this site, and the average hours per week of patient care, even if the service is not practiced as a specialty:

Service	Hours
General pediatric medical care	
General adolescent medical Care	
General adult medical care	
General geriatric medical care	
General gynecological medical care	
General obstetric medical care	

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

7(c). WORK SITE: NUMBER THREE

Name of Practice(s): \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 Town: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is your practice at this site affiliated with an **IPA HMO**? \_\_\_Yes \_\_\_No  
 Is your practice at this site affiliated with a **Group/Staff HMO**? \_\_\_Yes \_\_\_No  
 Do you engage in **teaching** at this site? \_\_\_Yes \_\_\_No  
 Do you engage in **research** at this site? \_\_\_Yes \_\_\_No

Is your **personal** income from this practice site based on (check as many as apply):  
 \_\_\_Salary \_\_\_Fee for service \_\_\_Capitation \_\_\_Cost based \_\_\_Other (please specify) \_\_\_\_\_

The codes to be used for the PRACTICE SETTING column are as follows:

1 Solo Practice	7 Hospital Owned/Operated Office Practice
2 Group Practice: Single Specialty	8 Hospital Emergency Room
3 Group Practice: Multi-Specialty	9 Hospital Outpatient Clinic
4 FQHC/RHC Community Health Center	10 Hospital Inpatient
5 School or College Health Center	11 Extended Care Facility
6 Business or Worksite	12 Other: Specify _____

Please complete one full line for each **SPECIALTY** that **YOU** practice at this site.

SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new <b>Medicaid</b> patients in this specialty? YES or NO	Will you accept new <b>Medicare</b> patients in this specialty? YES or NO

Check the types of **primary care** services that you perform at this site, and the average hours per week of patient care, even if the service is not practiced as a specialty:

Service	Hours
General pediatric medical care	
General adolescent medical Care	
General adult medical care	
General geriatric medical care	
General gynecological medical care	
General obstetric medical care	

VERMONT DEPARTMENT OF HEALTH SURVEY

SECTION IV CONTINUED

7(d). WORK SITE: NUMBER FOUR

Name of Practice(s): \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 Town: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is your practice at this site affiliated with an **IPA HMO**? \_\_\_Yes \_\_\_No  
 Is your practice at this site affiliated with a **Group/Staff HMO**? \_\_\_Yes \_\_\_No  
 Do you engage in **teaching** at this site? \_\_\_Yes \_\_\_No  
 Do you engage in **research** at this site? \_\_\_Yes \_\_\_No

Is your **personal** income from this practice site based on (check as many as apply):  
 \_\_\_Salary \_\_\_Fee for service \_\_\_Capitation \_\_\_Cost based \_\_\_Other (please specify) \_\_\_\_\_

The codes to be used for the PRACTICE SETTING column are as follows:

1 Solo Practice	7 Hospital Owned/Operated Office Practice
2 Group Practice: Single Specialty	8 Hospital Emergency Room
3 Group Practice: Multi-Specialty	9 Hospital Outpatient Clinic
4 FQHC/RHC Community Health Center	10 Hospital Inpatient
5 School or College Health Center	11 Extended Care Facility
6 Business or Worksite	12 Other: Specify _____

Please complete one full line for each SPECIALTY that YOU practice at this site.

SPECIALTY(IES) AT THIS SITE (Please use code(s) from the list of specialty codes.)	Average hours per week engaged in DIRECT PATIENT CARE	Practice Setting (use codes provided above on this page)	Do you plan to continue the practice of this specialty for the next 12 months? YES or NO	Will you accept new patients in this specialty? YES or NO	Will you accept new <b>Medicaid</b> patients in this specialty? YES or NO	Will you accept new <b>Medicare</b> patients in this specialty? YES or NO

Check the types of **primary care** services that you perform at this site, and the average hours per week of patient care, even if the service is not practiced as a specialty:

Service	Hours
General pediatric medical care	
General adolescent medical Care	
General adult medical care	
General geriatric medical care	
General gynecological medical care	
General obstetric medical care	