r. 1/9/97 Pd LF

42-6920 Glowa, Patricia T.

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE ONE OF EIGHT

JAN 1997
Vermont Board of Medical Practice

I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/96 to 11/30/98. **TWO YEAR RENEWAL FEE: *$300.00.***
Enclose a check in the amount of ***$300.00*** made payable to the Vermont Board of Medical Practice.

Patricia T. Glowa
[redacted]

**********[redacted]**********

**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.
- Do not remove any pages from this document.
-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: Patricia T. Glowa

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 [redacted]

City, State, Zip Code: [redacted]

5. Office Address: [redacted] Community Health Center
1 Medical Center Drive

City, State, Zip Code: [redacted] Lebanon, NH 03766

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

6. Daytime Telephone Number: [redacted] (603) 650-4000

7. Date of Birth: [redacted]

8. Sex (M/F): F

9. Are you currently active in clinical practice in Vermont? ✓ Yes (✓ No)
see 6a) - occasional volunteer free care not a regular site of clinical practice

42-6920 Glowa, Patricia T.

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF EIGHT

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.): BA Year of Graduation: 1973

Major Course of Study: _____

Degree Granting Institution: City College of City University of New York

Location: New York, N.Y.

First Institution (If transfer): McGill University

Location: Montreal, P.Q. Canada

12. Medical Degree: (M.D. or Other, please specify): MD 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):

(a) _____

(b) _____

(c) _____

(d) _____

(e) _____

14. Other states where you hold an active license to practice: New Hampshire; New York

15. States where you were previously licensed to practice: North Carolina

42-6920 Glowa, Patricia T.

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE THREE OF EIGHT

SECTION I CONTINUED

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

| | Specialty Code | Specialty Name | Board Certified ([Y]es/[N]o) | Year Certified/Recertified |
|---|---|---|---|---|
| (a) | 601 | Family Practice | Y | 1980/1986/1992 |
| (b) | | | | / |
| (c) | | | | / |

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

| | Residency Institution #1 | Residency Institution #2 | Residency Institution #3 |
|---|---|---|---|
| Institution Name | Highland Hospital | | |
| City | Rochester | | |
| State | NY | | |
| Country | USA | | |
| Specialty Code (See list) | 601 | | |
| Specialty Name | Family Practice | | |
| Year Residency Completed | 7/97 - 6/80 | | |

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, FOUR OF EIGHT

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42-6920 Glowa, Patricia T.

**STATE OF VERMONT - BOARD OF MEDICAL PRACTICE**
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FIVE OF EIGHT

**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
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE SIX OF EIGHT

**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 1996-1998 period if the answer to any of the questions above changes from "No" to "Yes".**

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE SEVEN OF EIGHT

## SECTION III

### Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions

**IMPORTANT: WITHOUT EXCEPTION, ALL LICENSEES MUST COMPLETE (1), (2), (3), (4) AND (5) BELOW OR THE LICENSE WILL NOT BE RENEWED. THANK YOU FOR YOUR COOPERATION.**

### 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 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".

### Regarding Taxes

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

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

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

**or**

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

(continued on page 8)

**YOU MUST COMPLETE OTHER SIDE**

42-6920 Glowa, Patricia T.

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1996 - 1998 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE EIGHT OF EIGHT

## SECTION III CONTINUED

**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 two 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 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 unemployment contributions or payments in lieu of unemployment contributions due to the 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".

4. **SOCIAL SECURITY NUMBER:** [redacted]* DATE OF BIRTH: [redacted]

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

5. **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: 1/7/97 Signature: Patricia T. Glowa

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

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

QUESTIONS?: (802) 828-2673

**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 $300.00* in check or money order payable to the Vermont Board of Medical Practice.

***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.

VERMONT DEPARTMENT OF HEALTH SURVEY

# SECTION IV

42-6920 Glowa, Patricia T.

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)

1. (a) Check **all** of the activities that describe your current status as a physician:
   - __ Active in clinical practice in Vermont
   - ✓ Active in clinical practice outside Vermont
   - ✓ Administration
   - ✓ Teaching
   - __ Research
   - __ Retired
   - __ Other

   (b) How many hours per week do you spend on administration, teaching and research? 25-30 hours

2. Postgraduate training in Vermont:
   (a) Are you currently in a postgraduate training program in Vermont as a resident or clinical fellow?
   __Yes ✓No **Note: If you answered YES, please answer questions (b) and (c)**
   (b) Are you a ___Resident ___Clinical Fellow ___Research Fellow?
   (c) What is the medical school that you are affiliated with for this training?
   ___University of Vermont ___Dartmouth ___Other (Please specify)_____

***** <u>Note:</u> If you are providing patient care in Vermont, <u>CONTINUE</u>.**
**Otherwise, <u>STOP</u> and return this survey with your relicensing application.**

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. Do you plan to retire or reduce your patient care hours in the next 12 months? ___Yes ✓No

SECTION IV CONTINUED

Instructions for completing this portion:

* Estimate if exact figures are not available.
* Please complete a WORK SITE section for each location where you provide patient care.
* Do not include, as a separate site, hospitals and nursing homes where you provide care to patients normally seen in an outpatient/office setting.
* Be as detailed as possible.
* Use the enclosed yellow sheet to make selections for the Specialty Code and Specialty Name columns.
* Do not remove any pages from this document.

**6(a). WORK SITE: NUMBER ONE**

Town: Wilder County: _____

(*Note: Enter the town and county in which the site is located, not a mailing address or Post Office box.)

Check the **ONE** practice setting from the selections below that most accurately reflects your practice at this site:

PRACTICE SETTINGS

___ Solo Practice
___ Group Practice
✓ Community Health Center or Clinic (Non-Hospital)
___ Hospital Outpatient Clinic
___ School or College Health Center
___ Business or Work Site
___ Hospital Emergency Room
___ Hospital Inpatient
___ Extended Care Facility / Nursing Home
___ Other: Specify

Average hours per week that you spend at this site providing DIRECT PATIENT CARE. **Include** both AMBULATORY CARE and HOSPITAL CARE of patients who originate from this site. Please **exclude** on-call hours.

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

| | Specialty Code | Specialty Name | Hours Per Week |
|---|---|---|---|
| Primary Specialty at this Site | 601 | Family Practice | * |
| Secondary Specialty at this Site | | | |
| Other Specialty at this Site | | | |

* 3-4 hours every 1-2 months - volunteer - Good Neighbor Health Center - indigent, free care

Do you plan to continue practice at this site for the next 12 months? ✓ Yes ___ No

Will you accept new patients at this site? ___ Yes ___ No

Will you accept new Medicaid patients at this site? ___ Yes ✓ No

Will you accept new Medicare patients at this site? ___ Yes ___ No

Are you working with physician's assistants and/or nurse practitioners at this site? ✓ Yes ___ No
If yes, enter the number of: Physician's Assistants _____ Nurse Practitioners 1

For FAMILY and GENERAL PRACTITIONERS, PEDIATRICIANS and INTERNISTS (primary care): Do you provide primary care services to adolescents (ages 10-20) at this site? ✓ Yes ___ No

For FAMILY and GENERAL PRACTITIONERS: Which of the following obstetrical services do you provide to patients from this site? _____ Prenatal care and delivery ✓ Prenatal care only _____ No obstetrical services provided

SECTION IV CONTINUED

Instructions for completing this portion:

* Estimate if exact figures are not available.
* Please complete a WORK SITE section for each location where you provide patient care.
* Do not include, as a separate site, hospitals and nursing homes where you provide care to patients normally seen in an outpatient/office setting.
* Be as detailed as possible.
* Use the enclosed yellow sheet to make selections for the Specialty Code and Specialty Name columns.
* Do not remove any pages from this document.

**6(b). WORK SITE: NUMBER TWO**

Town: _____ County: _____

(*Note: Enter the town and county in which the site is located, not a mailing address or Post Office box.)

Check the **ONE** practice setting from the selections below that most accurately reflects your practice at this site:

PRACTICE SETTINGS

___ Solo Practice
___ Group Practice
___ Community Health Center or Clinic (Non-Hospital)
___ Hospital Outpatient Clinic
___ School or College Health Center
___ Business or Work Site
___ Hospital Emergency Room
___ Hospital Inpatient
___ Extended Care Facility / Nursing Home
___ Other: Specify

Average hours per week that you spend at this site providing DIRECT PATIENT CARE. **Include** both AMBULATORY CARE and HOSPITAL CARE of patients who originate from this site. Please **exclude** on-call hours.

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

| | Specialty Code | Specialty Name | Hours Per Week |
|---|---|---|---|
| Primary Specialty at this Site | | | |
| Secondary Specialty at this Site | | | |
| Other Specialty at this Site | | | |

Do you plan to continue practice at this site for the next 12 months? ___Yes ___No

Will you accept new patients at this site? ___Yes ___No

Will you accept new Medicaid patients at this site? ___Yes ___No

Will you accept new Medicare patients at this site? ___Yes ___No

Are you working with physician's assistants and/or nurse practitioners at this site? ___Yes ___No
If yes, enter the number of: Physician's Assistants _____ Nurse Practitioners _____

For FAMILY and GENERAL PRACTITIONERS, PEDIATRICIANS and INTERNISTS (primary care): Do you provide primary care services to adolescents (ages 10-20) at this site? ___Yes ___No

For FAMILY and GENERAL PRACTITIONERS: Which of the following obstetrical services do you provide to patients from this site? _____Prenatal care and delivery _____Prenatal care only _____No obstetrical services provided

SECTION IV CONTINUED

Instructions for completing this portion:

* Estimate if exact figures are not available.
* Please complete a WORK SITE section for each location where you provide patient care.
* Do not include, as a separate site, hospitals and nursing homes where you provide care to patients normally seen in an outpatient/office setting.
* Be as detailed as possible.
* Use the enclosed yellow sheet to make selections for the Specialty Code and Specialty Name columns.
* Do not remove any pages from this document.

**6(c). WORK SITE: NUMBER THREE**

Town: _____ County: _____

(*Note: Enter the town and county in which the site is located, not a mailing address or Post Office box.)

Check the **ONE** practice setting from the selections below that most accurately reflects your practice at this site:

PRACTICE SETTINGS

___ Solo Practice
___ Group Practice
___ Community Health Center or Clinic (Non-Hospital)
___ Hospital Outpatient Clinic
___ School or College Health Center
___ Business or Work Site
___ Hospital Emergency Room
___ Hospital Inpatient
___ Extended Care Facility / Nursing Home
___ Other: Specify

Average hours per week that you spend at this site providing DIRECT PATIENT CARE. **Include** both AMBULATORY CARE and HOSPITAL CARE of patients who originate from this site. Please **exclude** on-call hours.

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

| | Specialty Code | Specialty Name | Hours Per Week |
|---|---|---|---|
| Primary Specialty at this Site | | | |
| Secondary Specialty at this Site | | | |
| Other Specialty at this Site | | | |

Do you plan to continue practice at this site for the next 12 months? ___Yes ___No

Will you accept new patients at this site? ___Yes ___No

Will you accept new Medicaid patients at this site? ___Yes ___No

Will you accept new Medicare patients at this site? ___Yes ___No

Are you working with physician's assistants and/or nurse practitioners at this site? ___Yes ___No
If yes, enter the number of: Physician's Assistants _____ Nurse Practitioners _____

For FAMILY and GENERAL PRACTITIONERS, PEDIATRICIANS and INTERNISTS (primary care): Do you provide primary care services to adolescents (ages 10-20) at this site? ___Yes ___No

For FAMILY and GENERAL PRACTITIONERS: Which of the following obstetrical services do you provide to patients from this site? _____Prenatal care and delivery _____Prenatal care only _____No obstetrical services provided

SECTION IV CONTINUED

Instructions for completing this portion:

* Estimate if exact figures are not available.
* Please complete a WORK SITE section for each location where you provide patient care.
* Do not include, as a separate site, hospitals and nursing homes where you provide care to patients normally seen in an outpatient/office setting.
* Be as detailed as possible.
* Use the enclosed yellow sheet to make selections for the Specialty Code and Specialty Name columns.
* Do not remove any pages from this document.

**6(c). WORK SITE: NUMBER FOUR**

Town: _____ County: _____

(*Note: Enter the town and county in which the site is located, not a mailing address or Post Office box.)

Check the **ONE** practice setting from the selections below that most accurately reflects your practice at this site:

PRACTICE SETTINGS

___ Solo Practice
___ Group Practice
___ Community Health Center or Clinic (Non-Hospital)
___ Hospital Outpatient Clinic
___ School or College Health Center
___ Business or Work Site
___ Hospital Emergency Room
___ Hospital Inpatient
___ Extended Care Facility / Nursing Home
___ Other: Specify

Average hours per week that you spend at this site providing DIRECT PATIENT CARE. **Include** both AMBULATORY CARE and HOSPITAL CARE of patients who originate from this site. Please **exclude** on-call hours.

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

| | Specialty Code | Specialty Name | Hours Per Week |
|---|---|---|---|
| Primary Specialty at this Site | | | |
| Secondary Specialty at this Site | | | |
| Other Specialty at this Site | | | |

Do you plan to continue practice at this site for the next 12 months? ___Yes ___No

Will you accept new patients at this site? ___Yes ___No

Will you accept new Medicaid patients at this site? ___Yes ___No

Will you accept new Medicare patients at this site? ___Yes ___No

Are you working with physician's assistants and/or nurse practitioners at this site? ___Yes ___No
If yes, enter the number of: Physician's Assistants _____ Nurse Practitioners _____

For FAMILY and GENERAL PRACTITIONERS, PEDIATRICIANS and INTERNISTS (primary care): Do you provide primary care services to adolescents (ages 10-20) at this site? ___Yes ___No

For FAMILY and GENERAL PRACTITIONERS: Which of the following obstetrical services do you provide to patients from this site? _____Prenatal care and delivery _____Prenatal care only _____No obstetrical services provided