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

DEC 1992
VERMONT BOARD of Medical Practi

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.

42-0005419 A

PHILIP F WATERMAN, II MD
2780 CLEVELAND AVENUE
SUITE 819
FORT MYERS, FL 33901

****

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: PHILIP F WATERMAN II MD 2. Vermont License Number: 42- 5419

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: 2780 CLEVELAND AVE SUITE 819

City, State, Zip Code: FORT MYERS FL 33901

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

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

8. Place of Birth: [redacted] 9. Sex: X 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: 1970

Degree Granting Institution: UNIV. OF MICHIGAN Location: ANN ARBOR, MI.
First Institution (If transfer): NORTHWESTERN U. Location: EVANSTON, ILL

12. Medical Degree - Circle: (M.D.) Other: ___ Year of Graduation: 1974

Degree Granting Medical School: UNIV. OF MICHIGAN Location: ANN ARBOR MI

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

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

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: FLORIDA

16. States where you previously were licensed to practice: MICHIGAN, NEW YORK

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) OB-GYN	✓ Yes	____ No Year Certified/Recertified: 1981/____
(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) UNIV. OF VERMONT	BURLINGTON	VT	OB-GYN	1978
(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 yo[redacted] medicine or to function as a student of medicine, resident or fellow?

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]

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE THREE OF SIX
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 b[redacted]is application?

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.**

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) _____/_____

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

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

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 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.

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: 11/30/92 **Signature:** Philip F. Waterman III MD

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 - 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.**

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? _____

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

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? _____

FORM A - PLEASE PROVIDE EXPLANATIONS TO SECTION II "YES" ANSWERS ON THIS FORM

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

Your Name: Philip F. Waterman II, MD Vermont License Number: 42-3000541 9

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) You will need TABLE I on Page 3 to complete this section. Please supply the following information regarding each instance of alleged malpractice: This form should be photocopied and filled out separately for each claim. Additional sheets may be attached if necessary. Please type or print cle

[redacted]

Insurer: _____

Claiman _____

Description of Alleged Basis(es) of Claim (Allegations Only: This does not constitute an admission of fault or liability.) See Codes on TABLE I, Page 3.

Basis Code [redacted] Basis Code: _____ _____ _____

Basis Code: _____ _____ _____ Basis Code: _____ _____ _____

Additional Descriptive Information - Please indicate:
1) Patient's condition at point of your involvement;
2) Patient's condition at end of treatment;
3) The nature and extent of your involvement with the patient; and
4) Your degree of responsibility for the course of treatment in leading to the claim.

[redacted]

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

[redacted]

Section A continued on next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF SIX

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) CONTINUED

Your Role (circle one):

01 Anesthesiologist
02 Primary Care Physician
03 Referring Physician
04 Attending Physician
05 Consultant Specialist
06 Surgeon
07 Fellow
08 PGY 1
09 PGY 2
10 PGY 3
11 PGY 4
12 PGY 5
13 PGY 6
14 PGY 7
15 Workmen's Compensation Evaluator
16 Court Psychiatrist
17 On-Call Physician
18 Group Practitioner/Partner
(19) Other: Specify Assistant surgeon
20 Unknown

Legal Representative (inclu[redacted]mber):

Name [redacted]

Firm: [redacted]

Addre[redacted]

City, S[redacted]

Teleph[redacted]

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:
Decision determined by (Check one): _____ Judge _____ Jury _____ Arbitration Panel
Decision:_____ Award: _____

If your case was appealed, indicate the following: Date Appeal Filed (Month, Day, Year) ____/____/____
Date Appeal Decided: _____/_____/_____

If your case was settled, indicate the following:
Settlement amount paid on your behalf: _____
Total settlement amount: _____
[redacted]

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

[redacted]

Table I for Section A on the next page

ASSOCIATES IN OBSTETRICS & GYNECOLOGY

K.K. YANKOPOLUS, M.D., F.A.C.O.G.
PHILIP F. WATERMAN II, M.D., F.A.C.O.G., F.A.C.S.
RANDALL P. COWDIN, M.D., F.A.C.O.G.
STUART DON LEVY, M.D., F.A.C.O.G.
SARA J. BRETZ, RNC - NURSE PRACTITIONER

☐ 2780 CLEVELAND AVENUE
SUITE 819
FORT MYERS, FLORIDA 33901
813-334-2256

☐ 1435 S.E. 8TH TERRACE
SUITE E
CAPE CORAL, FLORIDA 33904
813-574-2312

☐ 350 MARY STREET
PUNTA GORDA, FLORIDA 33952
813-639-8111

November 10, 1986.

[redacted]

Attn: [redacted]
Senior Claim Representative

Re: [redacted]

Dear [redacted]

[redacted]

Sincerely,

Philip F. Waterman II, M.D., FACOG. FACS.
PFW/vp

FORM A - PLEASE PROVIDE EXPLANATIONS TO SECTION II "YES" ANSWERS ON THIS FORM

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

Your Name: Philip F. Wakeman II, MD Vermont License Number: 42-30005419

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) You will need TABLE I on Page 3 to complete this section. Please supply the following information regarding each instance of alleged malpractice: This form should be photocopied and filled out separately for each claim. Additional sheets may be attached if necessary. Please type or print clearly.

Insure[redacted]

Claim[redacted]

Description of Alleged Basis(es) of Claim (Allegations Only: This does not constitute an admission of fault or liability.) See Codes on TABLE I, Page 3.

Basis Code: [redacted] Basis Code: _____ _____ _____

Basis Code: _____ _____ _____ Basis Code: _____ _____ _____

Additional Descriptive Information - Please indicate:
1) Patient's condition at point of your involvement;
2) Patient's condition at end of treatment;
3) The nature and extent of your involvement with the patient; and
[redacted]

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

[redacted]

[redacted]

Section A continued on next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF SIX

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) CONTINUED

Your Role (circle one):

01 Anesthesiologist
02 Primary Care Physician
03 Referring Physician
04 Attending Physician
05 Consultant Specialist
06 Surgeon
07 Fellow
08 PGY 1
09 PGY 2
10 PGY 3
11 PGY 4
12 PGY 5
13 PGY 6
14 PGY 7
15 Workmen's Compensation Evaluator
16 Court Psychiatrist
17 On-Call Physician
18 Group Practitioner/Partner
19 Other: Specify _____
20 Unknown

Legal Representative (include name, address, telephone number)

[redacted]

Name: _____

Firm: _____

Address _____

City, St _____

Telepho _____

Indicate Decision, Appeal, Settlement, Dismissal:

If a Court or Arbitration Panel heard your case, indicate the following:
Decision determined by (Check one): _____ Judge _____ Jury _____ Arbitration Panel
Decision:_____ Award: _____

If your case was appealed, indicate the following: Date Appeal Filed (Month, Day, Year) ____/____/____
Date Appeal Decided: _____/_____/_____

If your case was settled, indicate the following:
Settlement amount paid on your behalf: _____
Total settlement amount: _____
Date of Settlement: (Month, Day, Year) ____/____/____

[redacted]

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

[redacted]

Table I for Section A on the next page

ASSOCIATES IN OBSTETRICS & GYNECOLOGY

K. K. Yankopolus, M.D., F.A.C.O.G.
Philip F. Waterman II, M.D., F.A.C.O.G., F.A.C.S.
Randall P. Cowdin, M.D., Diplomate, A.B.O.G.
Stuart D. Levy, M.D., Diplomate, A.B.O.G.

January 20, 1986.

[redacted]

Dear [redacted]

[redacted]

-- continued

2780 Cleveland Avenue • Suite 819 • Fort Myers, Florida 33901 • (813) 334-2256
Offices also in Cape Coral

[redacted]

Sincerely,

Philip F. Waterman II, M.D., FACOG, FACS.
PFW/vp

FORM A - PLEASE PROVIDE EXPLANATIONS TO SECTION II "YES" ANSWERS ON THIS FORM

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

Your Name: Philip F. Wakerman II, MD Vermont License Number 42-3000419

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) You will need TABLE I on Page 3 to complete this section. Please supply the following information regarding each instance of alleged malpractice: This form should be photocopied and filled out separately for each claim. Additional sheets may be attached if necessary. Please type or print clea

[redacted]

Insurer: _____

Claimant _____

Description of Alleged Basis(es) of Claim (Allegations Only: This does not constitute an admission of fault or liability.) See Codes on TABLE I, Page 3.

Basis Code: [redacted] Basis Code: _____ _____ _____

Basis Code: _____ _____ _____ Basis Code: _____ _____ _____

Additional Descriptive Information - Please indicate:
1) Patient's condition at point of your involvement;
2) Patient's condition at end of treatment;
3) The nature and extent of your involvement with the patient; and
4) Your degree of responsibility for the course of treatment in leading to the claim.

[redacted]

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

[redacted]

Section A continued on next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF SIX

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) CONTINUED

Your Role (circle one):

01 Anesthesiologist
02 Primary Care Physician
03 Referring Physician
04 Attending Physician
05 Consultant Specialist
06 Surgeon
07 Fellow
08 PGY 1
09 PGY 2
10 PGY 3
11 PGY 4
12 PGY 5
13 PGY 6
14 PGY 7
15 Workmen's Compensation Evaluator
16 Court Psychiatrist
17 On-Call Physician
18 Group Practitioner/Partner
19 Other: Specify _____
20 Unknown

Legal Representative (include name, address and telephone number)

[redacted]

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard [redacted]

If your case was appealed, indicate the following: Date Appeal Filed (Month, Day, Year) ____/____/____
Date Appeal Decided: _____/_____/_____

If your case was settled, indicate the following:
Settlement amount paid on your behalf: _____
Total settlement amount: _____
Date of Settlement: (Month, Day, Year) _____/_____/_____

_____ Case dismissed against you _____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

[redacted]

Table I for Section A on the next page

October 24, 1985.

[redacted]

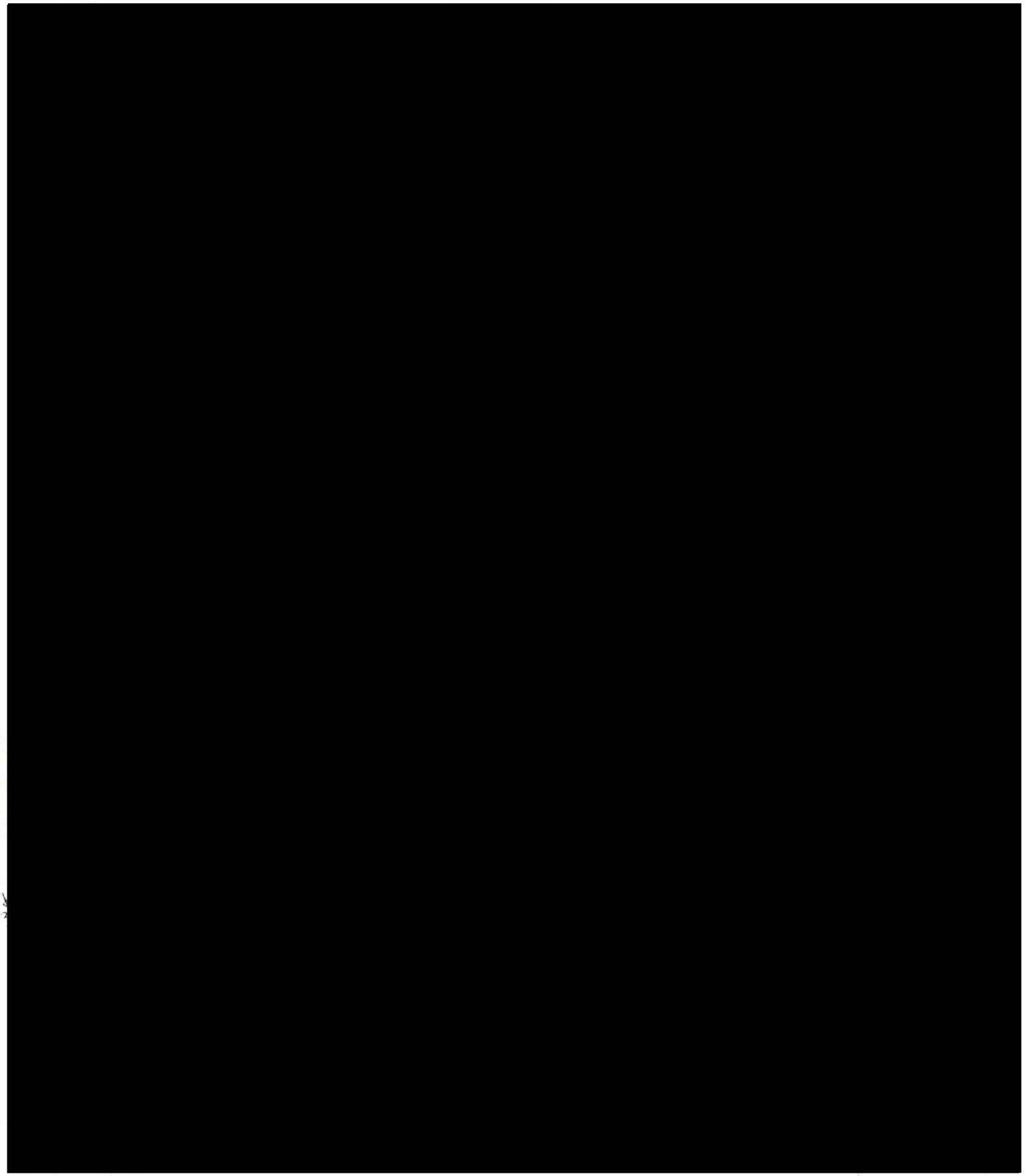
Re: [redacted]

Dear [redacted]

[redacted]

Page 2

-- continued



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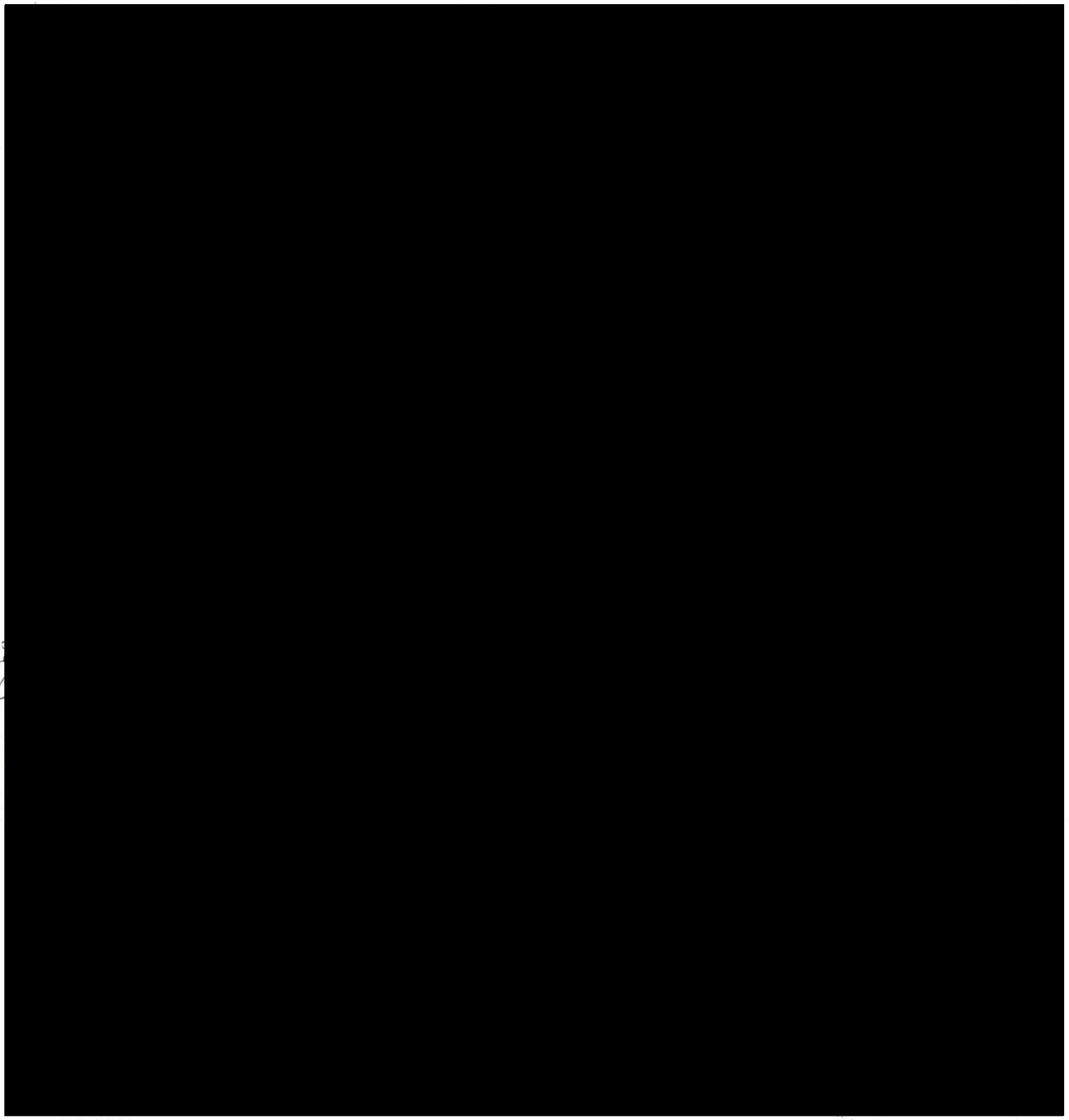

-- continued

Sincerely,

Philip F. Waterman II, M.D. FACOG, FACS
PFW/vp
Encls.

FORM A - PLEASE PROVIDE EXPLANATIONS TO SECTION II "YES" ANSWERS ON THIS FORM

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

Your Name: Philip F. Wakeman III, MD Vermont License Number 42-0005419

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) You will need TABLE I on Page 3 to complete this section. Please supply the following information regarding each instance of alleged malpractice: This form should be photocopied and filled out separately for each claim. Additional sheets may be attached if necessary. Please type or print c[redacted]

Insure[redacted]

Claim[redacted]

Description of Alleged Basis(es) of Claim (Allegations Only: This does not constitute an admission of fault or liability.) See Codes on TABLE I, Page 3.

Basis Code: [redacted] Basis Code: _____ _____ _____

Basis Code: _____ _____ _____ Basis Code: _____ _____ _____

Additional Descriptive Information - Please indicate:
1) Patient's condition at point of your involvement;
2) Patient's condition at end of treatment;
3) The nature and extent of your involvement with the patient; and
4) Your degree of responsibility for the course of treatment in leading to the claim.

[redacted]

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

[redacted]

Section A continued on next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF SIX

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) CONTINUED

Your Role (circle one):

01 Anesthesiologist
02 Primary Care Physician
03 Referring Physician
04 Attending Physician
05 Consultant Specialist
06 Surgeon
07 Fellow
08 PGY 1
09 PGY 2
10 PGY 3
11 PGY 4
12 PGY 5
13 PGY 6
14 PGY 7
15 Workmen's Compensation Evaluator
16 Court Psychiatrist
17 On-Call Physician
18 Group Practitioner/Partner
19 Other: Specify _____
20 Unknown

Legal [redacted] mber):

Name:

Firm:

Addres

City, St

Telepho

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:
Decision determined by (Check one): _____ Judge _____ Jury _____ Arbitration Panel
Decision:_____ Award: _____

If your case was appealed, indicate the following: Date Appeal Filed (Month, Day, Year) ____/____/____
Date Appeal Decided: _____/_____/_____

If your case was settled, indicate the following:
Settlement amount paid on your behalf: _____
Total settlement amount: _____
Date of Settlement: (Month, Day, Year) ____/____/____

[redacted]

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

[redacted]

Table I for Section A on the next page

Associates In Obstetrics And Gynecology

K.K. YANKOPOLUS, M.D., F.A.C.O.G.
PHILIP F. WATERMAN II, M.D., F.A.C.O.G., F.A.C.S.
RANDALL P. COWDIN, M.D., F.A.C.O.G.
STUART DON LEVY, M.D., F.A.C.O.G.
STEPHANIE VAN ZANDT, M.D.
SHELLEY A. YOUNG, M.D.
CYNTHIA A. ZELESNIK, A.R.N.P.

July 19, 1991

[redacted]

RE: [redacted]

Dear [redacted]

[redacted]

continued...

[redacted]

Sincerely,

Philip F. Waterman II, M.D., F.A.C.O.G., F.A.C.S.

[redacted]

FORM A - PLEASE PROVIDE EXPLANATIONS TO SECTION II "YES" ANSWERS ON THIS FORM

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

Your Name: Philip F. Waterman II, M.D. Vermont License Number: 42-3000 5419

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) You will need TABLE I on Page 3 to complete this section. Please supply the following information regarding each instance of alleged malpractice: This form should be photocopied and filled out separately for each claim. Additional sheets may be attached if necessary. Please type or print c[redacted]

Insure[redacted]

Claim[redacted]

Description of Alleged Basis(es) of Claim (Allegations Only: This does not constitute an admission of fault or liability.) See Codes on TABLE I, Page 3.

Basis Code: [redacted] Basis Code: _____ _____ _____

Basis Code: _____ _____ _____ Basis Code: _____ _____ _____

Additional Descriptive Information - Please indicate:
1) Patient's condition at point of your involvement;
2) Patient's condition at end of treatment;
3) The nature and extent of your involvement with the patient; and
4) Your degree of responsibility for the course of treatment in leading to the claim.

[redacted]

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

[redacted]

Section A continued on next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF SIX

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) CONTINUED

Your Role (circle one):

01 Anesthesiologist
02 Primary Care Physician
03 Referring Physician
04 Attending Physician
05 Consultant Specialist
06 Surgeon
07 Fellow
08 PGY 1
09 PGY 2
10 PGY 3
11 PGY 4
12 PGY 5
13 PGY 6
14 PGY 7
15 Workmen's Compensation Evaluator
16 Court Psychiatrist
17 On-Call Physician
18 Group Practitioner/Partner
19 Other: Specify _____
20 Unknown

Legal Representative (include name, address and telephone number):

[redacted]

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:
Decision determined by (Check one): _____ Judge _____ Jury _____ Arbitration Panel
Decision:_____ Award: _____

If your case was appealed, indicate the following: Date Appeal Filed (Month, Day, Year) ____/____/____
Date Appeal Decided: _____/_____/_____

If your case was settled, indicate the foll[redacted]
Settlement amount paid on your behalf: _____
Total settlement amount: _____
Date of Settlement: (Month, Day, Year) _____

_____ Case dismissed against you _____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

[redacted]

Table I for Section A on the next page

Associates In Obstetrics And Gynecology

K.K. YANKOPOLUS, M.D., F.A.C.O.G.
PHILIP F. WATERMAN II, M.D., F.A.C.O.G., F.A.C.S.
RANDALL P. COWDIN, M.D., F.A.C.O.G.
STUART DON LEVY, M.D., F.A.C.O.G.
STEPHANIE VAN ZANDT, M.D.
SHELLEY A. YOUNG, M.D.
CYNTHIA A. ZELESNIK, A.R.N.P.

February 12, 1991

RE: [redacted]

[redacted]

continued...

[redacted]

Sincerely,

Philip F. Waterman II, M.D., F.A.C.O.G., F.A.C.S.

[redacted]

FORM A - PLEASE PROVIDE EXPLANATIONS TO SECTION II "YES" ANSWERS ON THIS FORM

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

Your Name: Philip F. Waterman II, MD Vermont License Number: 42.0005419

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) You will need TABLE I on Page 3 to complete this section. Please supply the following information regarding each instance of alleged malpractice: This form should be photocopied and filled out separately for each claim. Additional sheets may be attached if necessary. Please type or print clearly

[redacted]

Insurer: _____

Claimant N _____

Description of Alleged Basis(es) of Claim (Allegations Only: This does not constitute an admission of fault or liability.) See Codes on TABLE I, Page 3.

Basis Code: [redacted] Basis Code: _____ _____ _____

Basis Code: _____ _____ _____ Basis Code: _____ _____ _____

Additional Descriptive Information - Please indicate:
1) Patient's condition at point of your involvement;
2) Patient's condition at end of treatment;
3) The nature and extent of your involvement with the patient; and
4) Your degree of responsibility for the course of treatment in leading to the claim.

[redacted]

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

[redacted]

Incident Location (circle one): [redacted]

Section A continued on next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF SIX

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) CONTINUED

Your Role (circle one):

01 Anesthesiologist
02 Primary Care Physician
03 Referring Physician
04 Attending Physician
05 Consultant Specialist
06 Surgeon
07 Fellow
08 PGY 1
09 PGY 2
10 PGY 3
11 PGY 4
12 PGY 5
13 PGY 6
14 PGY 7
15 Workmen's Compensation Evaluator
16 Court Psychiatrist
17 On-Call Physician
18 Group Practitioner/Partner
19 Other: Specify Good Samaritan
20 Unknown

Legal Representation (include name, address, telephone)

[redacted]

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:
Decision determined by (Check one): _____ Judge _____ Jury _____ Arbitration Panel
Decision:_____ Award: _____

If your case was appealed, indicate the following: Date Appeal Filed (Month, Day, Year) ____/____/____
Date Appeal Decided: _____/_____/_____

If your case was settled, indicate the following:
Settlement amount paid on your behalf: _____
Total settlement amount: _____

[redacted]

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

[redacted]

Table 1 for Section A on the next page

Philip F. Waterman II, M.D., F.A.C.O.G., F.A.C.S.

FORM A - PLEASE PROVIDE EXPLANATIONS TO SECTION II "YES" ANSWERS ON THIS FORM

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

Your Name: Philip F. Wakeman II, MD Vermont License Number: 42-3005419

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) You will need TABLE I on Page 3 to complete this section. Please supply the following information regarding each instance of alleged malpractice: This form should be photocopied and filled out separately for each claim. Additional sheets may be attached if necessary. Please type or print cl[redacted]

Insure[redacted]

Claim[redacted]

Description of Alleged Basis(es) of Claim (Allegations Only: This does not constitute an admission of fault or liability.) See Codes on TABLE I, Page 3.

Basis Code: [redacted] Basis Code: _____ _____ _____

Basis Code: _____ _____ _____ Basis Code: _____ _____ _____

Additional Descriptive Information - Please indicate:
1) Patient's condition at point of your involvement;
2) Patient's condition at end of treatment;
3) The nature and extent of your involvement with the patient; and
4) Your degree of responsibility for the course of treatment in leading to the claim.

[redacted]

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

[redacted]

Section A continued on next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF SIX

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) CONTINUED

Your Role (circle one):

01 Anesthesiologist
02 Primary Care Physician
03 Referring Physician
04 Attending Physician
05 Consultant Specialist
06 Surgeon
07 Fellow
08 PGY 1
09 PGY 2
10 PGY 3
11 PGY 4
12 PGY 5
13 PGY 6
14 PGY 7
15 Workmen's Compensation Evaluator
16 Court Psychiatrist
17 On-Call Physician
18 Group Practitioner/Partner
19 Other: Specify _____
20 Unknown

Legal Representative (include name, address and telephone number)

Name [redacted]

Firm:

Addres

City, S

Teleph

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indic
Decision determined by (Check one): _____ Judge _____ Jury _____ Arbitration Panel
Decision:_____ Award: _____

If your case was appealed, indicate the following: Date Appeal Filed (Month, Day, Year) ____/____/____
Date Appeal Decided: _____/_____/_____

If your case was settled, indicate the following:
Settlement amount paid on your behalf: _____
Total settlement amount: _____
Date of Settlement: (Month, Day, Year) _____/_____/_____

_____ Case dismissed against you _____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

[redacted]

Table I for Section A on the next page

Associates In Obstetrics And Gynecology

K.K. YANKOPOLUS, M.D., F.A.C.O.G.
PHILIP F. WATERMAN II, M.D., F.A.C.O.G., F.A.C.S.
RANDALL P. COWDIN, M.D., F.A.C.O.G.
STUART DON LEVY, M.D., F.A.C.O.G.
STEPHANIE VAN ZANDT, M.D.
SHELLEY A. YOUNG, M.D.
CYNTHIA A. ZELESNIK, A.R.N.P.

September 23, 1992

[redacted]

Philip F. Waterman II, M.D., F.A.C.O.G., F.A.C.S.

[redacted]

FORM A - PLEASE PROVIDE EXPLANATIONS TO SECTION II "YES" ANSWERS ON THIS FORM

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

Your Name: Philip F. Wakeman II, M.D. Vermont License Number: 42-3000549

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) You will need TABLE I on Page 3 to complete this section. Please supply the following information regarding each instance of alleged malpractice: This form should be photocopied and filled out separately for each claim. Additional sheets may be attached if necessary. Please type or print clear

[redacted]

Insurer: _____

Claimant _____

Description of Alleged Basis(es) of Claim (Allegations Only: This does not constitute an admission of fault or liability.) See Codes on TABLE I, Page 3.

Basis Code: [redacted] Basis Code: _____ _____ _____

Basis Code: _____ _____ _____ Basis Code: _____ _____ _____

Additional Descriptive Information - Please indicate:
1) Patient's condition at point of your involvement;
2) Patient's condition at end of treatment;
3) The nature and extent of your involvement with the patient; and
4) Your degree of responsibility for the course of treatment in leading to the claim.

[redacted]

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

[redacted]

Section A continued on next page

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF SIX

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 7) CONTINUED

Your Role (circle one):

01 Anesthesiologist
02 Primary Care Physician
03 Referring Physician
04 Attending Physician
05 Consultant Specialist
06 Surgeon
07 Fellow
08 PGY 1
09 PGY 2
10 PGY 3
11 PGY 4
12 PGY 5
13 PGY 6
14 PGY 7
15 Workmen's Compensation Evaluator
16 Court Psychiatrist
17 On-Call Physician
(18) Group Practitioner/Partner
19 Other: Specify _____
20 Unknown

Legal R

Name: [redacted]

Firm: [redacted]

Address [redacted]

City, St[redacted]

Telepho[redacted]

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicat[redacted]
Decision determined by (Check one): _____ Judge _____ Jury _____ Arbitration Panel
Decision:_____ Award: _____

If your case was appealed, indicate the following: Date Appeal Filed (Month, Day, Year) ____/____/____
Date Appeal Decided: _____/_____/_____

If your case was settled, indicate the following:
Settlement amount paid on your behalf: _____
Total settlement amount: _____
Date of Settlement: (Month, Day, Year) _____/_____/_____

_____ Case dismissed against you _____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

[redacted]

Table I for Section A on the next page

Philip F. Waterman II, M.D., F.A.C.O.G., F.A.C.S.

[redacted]

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1992-1994 PHYSICIAN LICENSE RENEWAL APPLICATION - PAGE SIX OF SIX

SECTION I: AFFECTING HEALTH CARE INSTITUTION STAFF PRIVILEGES, EMPLOYMENT OR APPOINTMENT (QUESTION 8) - ATTACH DOCUMENTS

Institution Involved: _____

Date: _____

Circumstances: _____

_____

_____

SECTION J: VOLUNTARILY SURRENDERED OR RESIGNED A LICENSE TO PRACTICE MEDICINE OR ANY HEALING ART (QUESTION 9) - ATTACH DOCUMENTS

State: _____ Year: _____

Circumstances: _____

_____

_____

SECTION K: DENIAL OF RIGHT TO PARTICIPATE OR ENROLL - THIRD PARTY PAYER (QUESTION 11) ATTACH DOCUMENTS

Third Party Payer: _____ Year: _____

Circumstances: _____

_____

_____

SECTION L: TURNED DOWN FOR COVERAGE BY MALPRACTICE INSURANCE CARRIER (QUESTION 13) ATTACH DOCUMENTS

[redacted]

SECTION M: SEVERITY LEVEL III NOTICE BY PEER REVIEW ORGANIZATION (PRO) (QUESTION 14) ATTACH DOCUMENTS

PRO: _____ Year: _____

Location of PRO: _____

Circumstances: _____

_____

_____