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.

****

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: PHILIP F. WATERMAN II M.D.
2. Vermont License Number: 42-0005419
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:
5. Office Address: 650 DEL PRADO BLVD. SUITE 100

   City, State, Zip Code: CAPE CORAL, FL 33990

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

6. Daytime Telephone Number: [redacted]
7. Date of Birth: [redacted]
8. Place of Birth: [redacted]
9. Sex (M/F): MALE

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.): ____ Year of Graduation: 1970

Major Course of Study: ECONOMICS

Degree Granting Institution: UNIV. OF MICHIGAN

Location: ANN ARBOR, MICHIGAN

First Institution (If transfer): NORTHWESTERN UNIV.

Location: EVANSTON, ILL.

12. Medical Degree: (M.D.) or Other, please specify): ____ Year of Graduation: 1974

Degree Granting Medical School: UNIV. OF MICHIGAN

Location: ANN ARBOR, MICHIGAN

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: NEW YORK, FLORIDA

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

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)	1 1 0 1	YES	1981 /
(b)	— — — —		/
(c)	— — — —		/

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
MED. CENTER HOSP. OF VERMONT	BURLINGTON	VT.	USA

Specialty Code (See attached list of specialty codes)	Year Completed
1101	1978

(b)

Institution	City	State	Country

Specialty Code (See attached list of specialty codes)	Year Completed

(a)

Institution	City	State	Country

Specialty Code (See attached list of specialty codes)	Year 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: Primary	and/or Secondary

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):

_____

_____

_____

SECTION I CONTINUED

This page was intentionally left blank.

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 **Medicaid** patients in this specialty? YES or NO	Will you accept new **Medicare** 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 **Medicaid** patients in this specialty? YES or NO	Will you accept new **Medicare** 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 **Medicaid** patients in this specialty? YES or NO	Will you accept new **Medicare** 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 **Medicaid** patients in this specialty? YES or NO	Will you accept new **Medicare** 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	

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)? THE FLORIDA DEPT. OF PROFESSIONAL REGULATION IS CURRENTLY REVIEWING TWO CASES ✓YES ___NO [redacted]

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? I VOLUNTARILY DROPPED MY OB PRIVILEGES AT CAPE CORAL HOSP. WHEN I WENT INTO SOLO PRACTICE I STILL HAVE MY GYN PRIVILEGES. ✓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? [redacted] ✓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? [redacted] ✓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
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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: [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.

(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: 1-3-95 **Signature:** Philip F. Waterman II MD

Return the completed form and fee to: Vermont Board of Medical Practice
(Return envelope enclosed) 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.**

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

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

Your Name: Philip F. Waterman II, M.D. **Vermont License Number:** 42-0005419

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 6) 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.

Insurer: [redacted]

Claimant Name [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 - 1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF SIX

SECTION A: MEDICAL MALPRACTICE CLAIM (QUESTION 6) CONTINUED

Your Role (circle one):

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

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION - PAGE FOUR OF SIX

SECTION B: CRIMINAL INVESTIGATION - PROCEEDING (QUESTIONS 2 AND 3) - ATTACH DOCUMENTS

Court: _____ Charge: _____ Date: _____

Description: _____

_____

_____

_____

Status: _____
Conviction?: _____ Date: _____
Plea?: _____ Date: _____

SECTION C: DISCIPLINARY CHARGES OR ACTION (QUESTION 5) - ATTACH DOCUMENTS

Name of Organization Involved: [redacted]

Duration: _____

Action Taken (circle all that apply): [redacted]

Circumstances: [redacted]

_____

_____

_____

SECTION D: PRIVILEGE TO PRESCRIBE CONTROLLED SUBSTANCES (QUESTION 9) - ATTACH DOCUMENTS

Name of Organization Involved: _____

Type of Restriction: _____ Date: _____

Circumstances of restriction: _____

_____

_____

_____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION - PAGE FIVE OF SIX

SECTION E: WITHDRAWAL OR DENIAL OF LICENSE (QUESTION 11) - ATTACH DOCUMENTS

State: _____ Year: _____

Circumstances under which license was withdrawn or denied (revoked, not renewed, or otherwise terminated):

_____

_____

SECTION F: INVESTIGATION BY ANY OTHER LICENSING BOARD (QUESTION 14) - ATTACH DOCUMENTS

Name of Licensing Board: _____ Date: _____

Location of Licensing Board: _____

Circumstances: _____ [redacted]

_____

_____

SECTION G: RESIDENCY TRAINING PROGRAM(S) NOT COMPLETED (QUESTION 15) - ATTACH DOCUMENTS

Residency Training Program(s): _____

Location of Program(s): _____ Year: _____

Circumstances: _____

_____

SECTION H: TREATMENT FOR EMOTIONAL DISTURBANCE OR MENTAL ILLNESS, ORGANIC ILLNESS, ALCOHOL OR DRUG DEPENDENCY (QUESTIONS 1 AND 4)

Treating Organization: _____

Address: _____

_____

Telephone: (_____) _____

Person Responsible for Treatment: _____

Type of Condition and Treatment: _____

_____

_____

_____

Dates of Illness/Dependency: _____ to _____

Dates of Treatment: _____ to _____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION - PAGE SIX OF SIX

SECTION I: AFFECTING HEALTH CARE INSTITUTION STAFF PRIVILEGES, EMPLOYMENT OR APPOINTMENT (QUESTION 7) - ATTA

Institution Involved: [redacted]

Date: [redacted]

[redacted]

SECTION J: VOLUNTARILY SURRENDERED OR RESIGNED A LICENSE TO PRACTICE MEDICINE OR ANY HEALING ART (QUESTION 8) - ATTACH DOCUMENTS

State: _____ Year: _____

Circumstances: _____

_____

_____

SECTION K: DENIAL OF RIGHT TO PARTICIPATE OR ENROLL - THIRD PARTY PAYER (QUESTION 10) ATTACH DOCUMENTS

Third Party Payer: [redacted] Year: [redacted]

[redacted]

SECTION L: TURNED DOWN FOR COVERAGE BY MALPRACTICE INSURANCE CARRIER (QUESTION 12) ATTACH DOCUMENTS

Malpractice Insurance Carrier [redacted]

[redacted]

SECTION M: CONFIRMED QUALITY CONCERN NOTICE BY PEER REVIEW ORGANIZATION (PRO) (QUESTION 13) ATTACH DOCUMENTS

PRO: _____ Year: _____

Location of PRO: _____

Circumstances: _____

_____

_____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1994-1996 PHYSICIAN LICENSE RENEWAL APPLICATION - PAGE THREE OF SIX
TABLE I - BASIS CODES - ALLEGATIONS ONLY

DIAGNOSIS RELATED
D01 Delay in Diagnosis
Failure to Diagnose:
D02 Abdominal Problems (other than appendicitis or ulcer)
D03 AIDS/AIDS Related Complex
D04 Allergy
D05 Appendicitis
D06 Arthritis
D07 Bladder Problem
D08 Bowel Problem
D09 Breast Cancer
D10 Cancer (other than breast)
D11 Cardiac Disorder/Illness/Problem (not myocardial infarction)
D12 Circulatory Problem
D13 Diabetes
D14 Fracture/Dislocation
D15 Gall Bladder Disorder
D16 Genetic Disorder
D17 Hemorrhage
D18 Hernia
D19 Implanted Foreign Body
D20 Infection
D21 Kidney Disorder
D22 Liver Disorder
D23 Meningitis
D24 Myocardial Infarction
D25 Neurological Disorder
D26 Orthopaedic Problem (other than fracture/dislocation)
D27 Pneumonia/Pneumothorax
D28 Poisoning
D29 Respiratory Problem
D30 Tendon Injury
D31 Thrombosis
D32 Tumor
D33 Ulcer or Complication(s) of Ulcer
D34 Other Specify: _____

D35 Failure to Obtain Consent for Diagnostic Procedures/Exceeding consent obtained
D36 Misdiagnosis
D37 Ordering/Performing Unnecessary Diagnostic Tests/Procedures
D38 Failure to Perform Diagnostic Test(s)
D39 Other Diagnosis Related Injury

EQUIPMENT
E01 Equipment: Misuse
E02 Equipment: Malfunction
E03 Equipment: Other Specify: _____

IMPROPER TREATMENT
T01 Delay in Treatment
T02 Failure to Obtain Informed Consent/Exceeding Consent Obtained
T03 Improper Choice of Treatment
T04 Infection
T05 Fracture/Dislocation
T06 Chronic Vegetative State Resulting from Medical Intervention

Improper Treatment: Anesthesia Related
T07 Failure to obtain informed consent/exceeding consent obtained
T08 Failure to take adequate patient history
T09 Failure to monitor
T10 Failure to test equipment/improper use of equipment
T11 Improper intubation
T12 Improper positioning
T13 Wrong amount/type of anesthesia prescribed
T14 Allergic/adverse reaction
T15 Teeth damage
T16 Other Specify: _____

TRANSFUSION
TR17 Mismatch
TR18 Caused AIDS
TR19 Caused Hepatitis
TR20 Other Specify: _____

Improper Treatment: Medication Related
T21 Failure to obtain informed consent/exceeding consent obtained
T22 Failure to take adequate patient history
T23 Failure to diagnose drug related problem(s) (other than addiction)
T24 Failure to diagnose drug addiction
T25 Prescribing to a known addict
T26 Wrong medication ordered
T27 Wrong dose of medication ordered
T28 Improper route of administration
T29 Drug side effect
T30 Failure to prescribe
T31 Drug toxicity/overdose
T32 Other Specify: _____

Improper Treatment: Mental Illness Related
T33 Failure to obtain informed consent/exceeding consent obtained
T34 Failure to diagnose mental disorder/illness/problem
T35 Improper medication prescribed
T36 Improper commitment
T37 Improper discharge
T38 Improper monitoring
T39 Improper use of seclusion/restraints
T40 Suicide/Suicide attempt by inpatient
T41 Suicide/Suicide attempt by outpatient
T42 Other Specify: _____

Improper Treatment: Obstetrics-Gynecology Related
T43 Failure to obtain informed consent/exceeding consent obtained
T44 Failure to diagnose pregnancy, normal
T45 Failure to diagnose pregnancy related problem
T46 Failure to diagnose ectopic pregnancy
T47 Failure to diagnose endometriosis
T48 Failure to diagnose fetal distress
T49 Failure to identify mother-fetus blood problem
T50 Improper performance of abortion
T51 Improper management of pregnancy
T52 Improper management of delivery
T53 Improperly performed vaginal delivery
T54 Improperly performed C-section
T55 Delay in performing C-section
T56 Delay in treating fetal distress
T57 Failed sterilization
T58 Wrongful life/birth
T59 Fetal death/stillborn
T60 Maternal death related to delivery
T61 Other Specify: _____

Improper Treatment: Surgery Related
T62 Failure to obtain informed consent/exceeding consent obtained
T63 Improper performance
T64 Failure to diagnose post-operative complications
T65 Improper treatment of post-operative complications
T66 Retained foreign bodies (e.g. needle, sponge, instrument, etc.)
T67 Delay in surgery
T68 Unnecessary surgery
T69 Wrong body part
T70 Laceration or penetration not within scope of surgery
T71 Death in the course of/resulting from surgery
T72 Other Specify: _____

Improper Treatment: Specified Procedures
T73 Angiography
T74 Arteriography
T75 CAT scan
T76 Catheterization
T77 Colonoscopy
T78 Cryosurgery
T79 Discogram
T80 Electroconvulsive Therapy
T81 Endoscopy
T82 Esophageal Dilatations
T83 Injection/Immunization
T84 Laparoscopy
T85 Lasers, used in treatment
T86 Myelography

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Regarding # 5 Section II

KOH

STATE OF FLORIDA
DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION
BOARD OF MEDICINE

DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION,

PETITIONER,

vs. CASE NO. 93-11602

PHILIP F. WATERMAN, II, M.D.,

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Department of Business and Professional Regulation, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against Philip F. Waterman, M.D., hereinafter referred to as "Respondent," and alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.165, Florida Statutes; Chapter 455, Florida Statutes; and Chapter 458, Florida Statutes.

2. Respondent is and has been at all times material hereto a licensed physician in the State of Florida, having been issued license number ME 0033129. Respondent's last known address is 650 Del Prado Boulevard, Suite 100, Cape Coral, Florida 33990.

3. Respondent is board certified in obstetrics and gynecology.

4. On or about April 11, 1990, Patient [redacted] a thirty (30) year-old female, presented to Respondent with complaints of a lump in her right breast.

5. Respondent examined Patient [redacted] and did not find a right breast lump.

6. During his examination of Patient [redacted] Respondent neither recommended that Patient [redacted] undergo further study of her breast lump nor that she return for a follow-up visit.

7. On or about April 11, 1991, Patient [redacted] presented to a partner of Respondent for her routine gynecological examination.

8. Patient [redacted] complained of the right breast mass to the physician.

9. Patient [redacted] subsequently underwent an aspiration, a biopsy and a mammogram of the mass. Said tests revealed the mass to be an infiltrating ductal carcinoma.

10. On or about May 17, 1991, Patient [redacted] underwent a right radical mastectomy.

11. Following the mastectomy, Patient [redacted] underwent chemotherapy and Tamoxifen therapy.

12. In or about May 1991, Patient [redacted] requested a copy of her medical records from Respondent. Included in said medical records was a copy of Respondent's initial record of his April 11, 1990, examination of Patient [redacted] which consisted of a handwritten note which stated "no mass found-somewhat fibrous."

13. In or about September 1991, Patient [redacted] requested a copy of her medical records for insurance purposes. Included in said

medical records was a copy of Respondent's initial handwritten record of his April 11, 1990, examination of Patient [redacted], as well as an additional typewritten record concerning said examination of Patient [redacted]

14. Said type-written entry stated Respondent examined Patient [redacted] right breast and could not find a mass. In addition, the entry stated Respondent instructed Patient [redacted] to return if she again felt the breast lump.

15. The type-written entry to Patient [redacted] medical record was not dated and was not listed as a "late entry."

16. The typewritten entry was added to Patient [redacted] medical record by Respondent subsequent to his visit with Patient [redacted] and subsequent to his initial handwritten record of his visit with Patient D.W.

Count One

17. Petitioner realleges and incorporates Paragraphs one (1) through sixteen (16) as if fully set forth herein this Count One.

18. Respondent is guilty of making deceptive, untrue, or fraudulent representations in or related to the practice of medicine or employing a trick or scheme in the practice of medicine in that Respondent altered Patient [redacted] medical records after his April 11, 1990, examination of her by adding an undated typewritten entry to the medical records concerning said physical examination.

19. Based on the foregoing, Respondent violated Section 458.331(1)(k), Florida Statutes, making deceptive, untrue, or fraudulent representations in or related to the practice of

medicine or employing a trick or scheme in the practice of medicine.

Count Two

20. Petitioner realleges and incorporates Paragraphs one 91) through sixteen (16) and eighteen (18) as if fully set forth herein this Count Two.

21. Respondent is guilty of failing to keep written medical records justifying the course of treatment of the patient in that Respondent's initial medical record concerning his examination of Patient [redacted] which occurred on or about April 11, 1990, only contained one sentence and did not adequately outline his examination of Patient [redacted] and in that Respondent altered Patient [redacted] medical records after the fact by adding a typewritten entry to the records.

22. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

Count Three

23. Petitioner realleges and incorporates Paragraphs one (1) through sixteen (16), eighteen (18), and twenty-one (21) as if fully set forth herein this Count Two.

24. Respondent is guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill,

and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances in that Respondent failed to maintain adequate medical records concerning his care and treatment of Patient D.W., Respondent altered Patient [redacted] medical records after the fact, and Respondent failed to recommend follow-up examinations and or treatments for Patient [redacted] in response to her complaints of a right breast lump which Respondent was unable to palpate upon examination.

25. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

WHEREFORE, the Petitioner respectfully requests the Board of Medicine enter an Order imposing one or more of the following penalties: permanent revocation or suspension of the Respondent's license, restriction of the Respondent's practice, imposition of an administrative fine, issuance of a reprimand, placement of the

Respondent on probation, and/or any other relief that the Board deems appropriate.

SIGNED this 31 day of May, 1994.

George Stuart, Secretary

Larry G. McPherson, Jr.
Chief Medical Attorney

COUNSEL FOR DEPARTMENT:

Larry G. McPherson, Jr.
Chief Medical Attorney
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RPC/sdb
PCP: May 26, 1994
Murray, Slade, and Varn

FILED
Department of Business and Professional Regulation
AGENCY CLERK

CLERK Sarah L. Workman
DATE 5-31-94

[redacted]

[redacted]

Regarding # 5 Section II

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
BOARD OF MEDICINE

AGENCY FOR HEALTH CARE ADMINISTRATION,
PETITIONER,
vs. CASE NO. 93-10435

PHILIP F. WATERMAN, II, M.D.,
RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Petitioner, Agency for Health Care Administration, hereinafter referred to as "Petitioner," and files this Administrative Complaint before the Board of Medicine against Philip F. Waterman, II, M.D., hereinafter referred to as "Respondent," and alleges:

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.165, Florida Statutes; Section 20.42, Florida Statutes, Chapter 455, Florida Statutes; and Chapter 458, Florida Statutes.

2. Respondent is and has been at all times material hereto a licensed physician in the State of Florida, having been issued license number ME 0033129. Respondent's last known address is 650 Del Prado Boulevard, Suite 100, Cape Coral, Florida 33990.

3. Respondent is Board Certified in Obstetric and Gynecology.

4. Patient [redacted] had been a patient of Respondent from June 1984.

5. Patient [redacted] a forty-six (46) year old female at approximately eight weeks pregnant, presented to Respondent on or

about October 20, 1992, for a prenatal visit, and underwent an ultrasound.

6. Respondent determined there was sufficient amniotic fluid for an amniocentesis, which is the extracting of fluid from the amniotic sac for evaluation.

7. Respondent attempted an amniocentesis on Patient [redacted], but was unsuccessful.

8. Respondent failed to obtain proper consultation for Patient [redacted] amniocentesis, early amniocentesis is a very difficult procedure that is not widely performed or recommended, and should be performed by a Maternal-Fetal medicine physician who does them of a routine basis.

9. Respondent did not document informed consent and consultation of risks involved from the procedure with a signed consent from Patient [redacted] for the amniocentesis.

10. On or about October 27, 1992, Patient [redacted] presented Respondent approximately nine (9) weeks pregnant and underwent another amniocentesis attempt, which was unsuccessful.

11. Respondent did not obtain a signed consent from Patient [redacted] for the amniocentesis.

12. Patient [redacted] subsequently developed vaginal bleeding.

13. On or about November 10, 1992, Patient M.M. presented Respondent at approximately ten (10) weeks, and underwent a successful amniocentesis.

14. Respondent inappropriately performed amniocentesis on Patient [redacted] who had uterine bleeding, increasing the risk of spontaneous abortion when there was no urgent time factor involved.

15. On or about November 17, 1992, Patient [redacted] presented to Respondent with complaints of vaginal bleeding, and was diagnosed with ruptured membranes.

16. Respondent prescribed bedrest and antibiotics for Patient [redacted]

17. On or about December 9, 1992, Patient [redacted] presented to Respondent with complaints of vaginal bleeding and cramps.

18. An ultrasound of Patient [redacted] did not show any fetal heart tones, and fetal parts were seen in the open cervix.

19. Respondent performed a dilation and curettage (D & C) on Patient [redacted] for evacuation of the uterus.

20. On or about December 17, 1992, Patient [redacted] presented to Respondent for a postoperative check-up, which reported normal results.

21. On or about December 22, 1992, Patient [redacted] presented another physician with complaints of persistent vaginal bleeding.

22. Patient [redacted] was diagnosed with retained products of conception after a D & C.

23. Patient [redacted] underwent a repeat D & C performed by the subsequent physician to evacuate the remaining material from the uterus.

Count One

24. Petitioner realleges and incorporates paragraph one (1) through twenty-three (23) as if full set forth herein this Count One.

25. Respondent is guilty of failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalization, in that Respondent failed to record notes documenting counseling and failed to obtain signed consent forms from Patient M.M. documenting informed consent for the first two amniocentesis.

26. Based on the foregoing, Respondent violated Section 458.331(1)(m), Florida Statutes, and is guilty of failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalization.

Count Two

27. Petitioner realleges and incorporates paragraph one (1) through twenty-three (23) and twenty-five (25) as if set full forth herein this Count Two.

28. Respondent is guilty of performing professional services which have not been duly authorized by the client, or his legal

representative, in that Respondent performed two (2) amniocentesis on Patient [redacted] without written consent.

29. Based on the foregoing, Respondent violated Section 458.331(1)(p), Florida Statutes, and is guilty of performing professional services which have not been duly authorized by the client, or his legal representative, except as provided in s. 743.064, s. 766.103, or s. 768.13.

Count Three

30. Petitioner realleges and incorporates paragraph one (1) through twenty-three (23), twenty-five (25) and twenty-eight (28) as if full set forth herein this Count Three.

31. Respondent is guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances, in that Respondent failed to refer Patient M.M. to proper consultation for amniocentesis and inappropriately attempted amniocentesis too early and inappropriately attempted a third amniocentesis on Patient [redacted]

32. Based on the foregoing, Respondent violated Section 458.331(1)(t), Florida Statutes, and is guilty of gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances.

WHEREFORE, the Petitioner respectfully requests the Board of Medicine enter an Order imposing one or more of the following penalties: permanent revocation or suspension of the Respondent's license, restriction of the Respondent's practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, and/or any other relief that the Board deems appropriate.

SIGNED this 16 day of December, 1994.

Douglas M. Cook, Director

Larry G. McPherson, Jr.
Chief Medical Attorney

COUNSEL FOR AGENCY:

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RPC/kjh
PCP: December 15, 1994
Murrau, Slade and Varn

FILED
AGENCY FOR
HEALTH CARE ADMINISTRATION
DEPUTY CLERK
CLERK Brandon L. Moore
DATE 12-19-94

[redacted]

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