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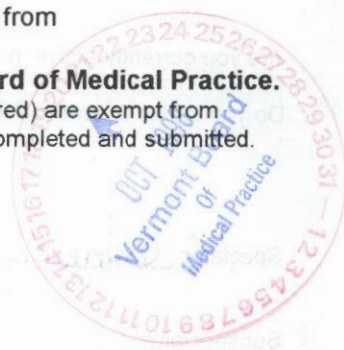
STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE ONE OF FIVE

I hereby apply for the renewal of my LICENSE AS A PHYSICIAN for the period from 12/01/98 to 11/30/2000. TWO YEAR RENEWAL FEE: \$300.

Enclose a check in the amount of \$300. made payable to the Vermont Board of Medical Practice.

Physicians 80 years of age or older or on full time active military duty (verification required) are exempt from payment of a renewal fee; however the physician license renewal application must be completed and submitted.

LATE FEE: Late applications are assessed a \$25 late fee.



042-0005419

Philip F. Waterman II, MD
650 Del Prado Blvd, Suite 100
Cape Coral, FL 33990

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

Name: Waterman Philip F.
(Last) (First) (Middle) (Former)

Vermont License Number: 042-0005419

Other Name(s), if any, under which you were licensed in Vermont and elsewhere since your last renewal: _____

Mailing Address: 650 Del Prado Blvd., Suite 100
(Street)

Cape Coral FL 33990 (941) 574-8200
(City) (State) (Zip Code) (Phone)

Office Address: Same As Above
(Street)

(City) (State) (Zip Code) (Phone)

Home Address: [REDACTED]

City, State, Zip Code: [REDACTED]
Note: Circle your preferred mailing address. Please note that this address will be public and listed on the Board's website.

Daytime Telephone Number: Area Code: [REDACTED]

**STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF FIVE**

Are you currently active in clinical practice in Vermont? ___ Yes No

Do you intend to practice medicine without hospital privileges? ___ Yes No

SPECIALTY

Specialty: Gynecology

Subspecialty: _____

American Specialty Board Certified? Yes ___ No

Specialty?: Am. Board OB-GYN Year Certified?: 1981

If applicable, year recertified? N/A

Subspecialty Certificate?: N/A Year Certified? _____

If applicable, year recertified? _____

PRACTICE

Do you have hospital privileges? Yes ___ No

List all hospitals where you have, or previously have had, staff privileges. Include name, address, and dates.

Name	Address	From/To	Specialty/Subspecialty
<u>Lee Memorial Health System</u>	<u>Ft. Myers FL</u>	<u>1978-Present</u>	<u>OB-GYN</u>
<u>Gulf Coast Hospital</u>	<u>Ft. Myers FL</u>	<u>1995-Present</u>	<u>OB-GYN</u>

OTHER LICENSES

Do you hold, or have you ever held, a medical license in any other state? Yes ___ No If yes, complete the section below.

State	License Number	Date Issued	Status (Active or Inactive)
<u>Florida</u>	<u>ME 0033129</u>	<u>11/21/97</u>	<u>Active</u>
<u>New York</u>	<u>3387397</u>	<u>Good until 2/28/00</u>	<u>Inactive</u>
<u>Michigan</u>	<u>35137</u>	<u>1975</u>	<u>Inactive</u>

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE THREE OF FIVE

SECTION II

SECTION II - "Yes" answers to Questions 1 - 24 require an explanation on the enclosed Form A.

Important note regarding the following questions: "Yes" answers on past 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 1998-2000 period if the answer to any of the questions on the next two pages changes from "No" to "Yes". (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 applied for and been denied a license to practice medicine or any healing art? Yes No
2. Have you withdrawn an application for a license to practice medicine or any healing art? Yes No
3. Have you voluntarily surrendered or resigned a license to practice medicine or any healing art in lieu of disciplinary action? Yes No
4. Are any formal disciplinary charges pending or has any disciplinary action been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? Yes No
5. To your knowledge, are you the subject of an investigation by any **other** licensing board as of the date of this application? Yes No
6. Have you been denied the privilege of taking an examination before any State Medical Examining Board? Yes No
7. Have you discontinued your education, training, or practice for a period of more than three months? Yes No
8. Have you been dismissed or asked to leave a residency training program(s) before completion? Yes No
9. Have you had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked; resigned from a medical staff in lieu of disciplinary action; or resigned from a medical staff after a complaint or peer review action has been initiated against you? Yes No
10. Have you been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill? Yes No
11. Have you 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
12. 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)? Yes No
13. Have you been turned down for coverage by a malpractice insurance carrier? Yes No
14. 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
15. Have you been a defendant in any criminal proceeding other than minor traffic offenses (Note: DWI - Driving While Intoxicated - is NOT a minor offense)? Yes No
16. To your knowledge, are you the subject of an investigation for a criminal act? Yes No

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FOUR OF FIVE

SECTION II CONTINUED - "Yes" answers to Questions 17 - 24 require an explanation on the enclosed Form A.
For purposes of Questions 17 - 24, the following phrases or words are defined below:

"Ability to practice medicine" is to be construed to include all of the following:

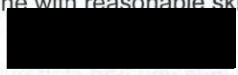
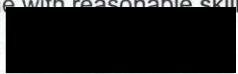

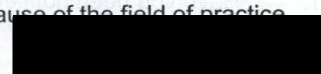
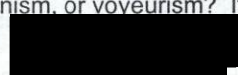
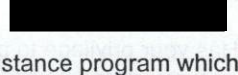

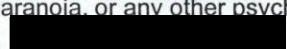
1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently", for purposes of this renewal application, does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

17. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If "yes," please explain. 
18. Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? If "yes," please explain. 
19. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If "yes," please explain. 
20. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If "yes," please explain. 
21. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If "yes," please explain. 
22. Are you currently engaged in the illegal use of controlled substances? 
23. If "yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not illegally using controlled substances? If "yes," please explain. 
24. Have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder? 

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

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
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Your Name: Philip F. Waterman II M.D.

MEDICAL MALPRACTICE CLAIM (QUESTION 12) 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: _____

Claimant Name: _____

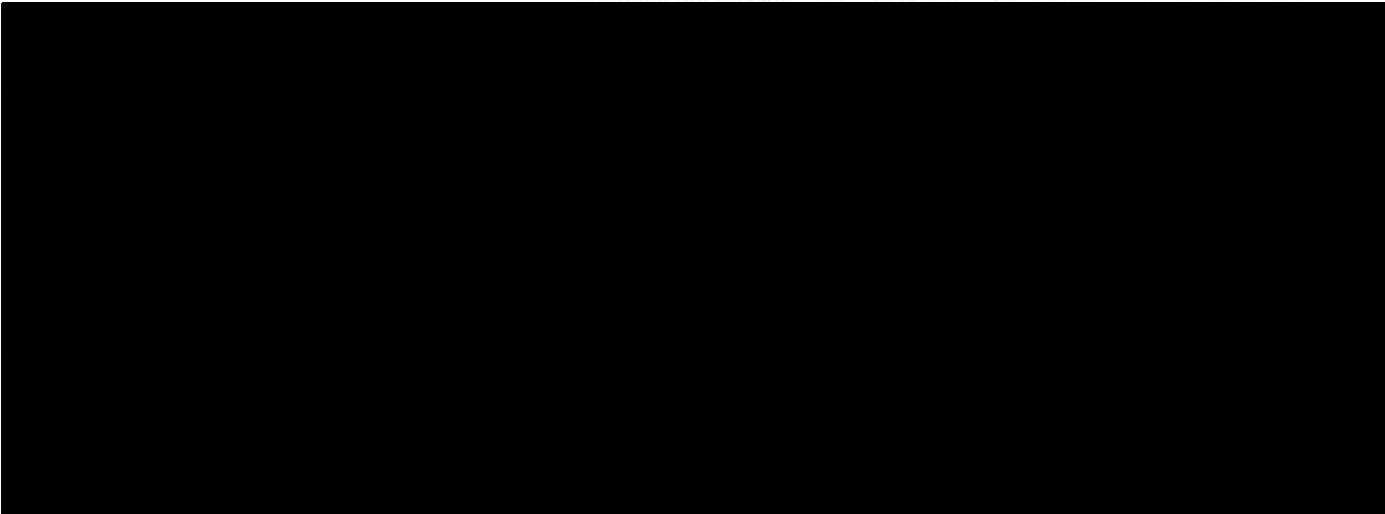
Description of Alleged Basis(es) of Claim (Allegations Only: This does not constitute an admission of fault or liability.) See Codes on TABLE I, Page 3.

Basis Code: _____ Basis Code: _____

Basis Code: _____ Basis Code: _____

Additional Descriptive Information - Please indicate:

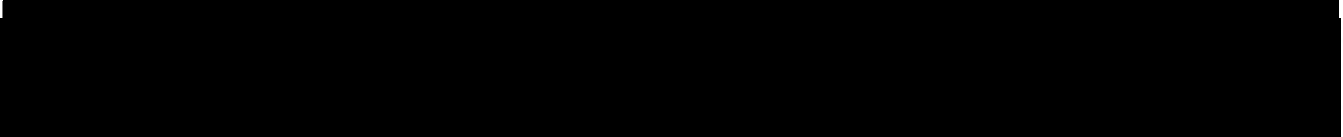
- 1) Patient's condition at point of your involvement;
- 2) Patient's condition at end of treatment;
- 3) The nature and extent of your involvement with the patient; and
- 4) Your degree of responsibility for the course of treatment in leading to the claim.



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



Incident Location (circle one):



STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED -1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE TWO OF SEVEN

MEDICAL MALPRACTICE CLAIM (QUESTION 12) 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):

Name: _____

Firm: _____

Address: _____

City, State, Zip: _____

Telephone Number: () _____

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:

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION
PAGE THREE OF SEVEN
TABLE I - BASIS CODES - QUESTION 12 - 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

**STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION
PAGE FOUR OF SEVEN**

WITHDRAWAL OR DENIAL OF LICENSE (QUESTIONS 1 & 2) ATTACH DOCUMENTS

State: _____ Year: _____

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

**VOLUNTARILY SURRENDERED OR RESIGNED A LICENSE TO PRACTICE MEDICINE OR ANY HEALING ART
(QUESTION 3) - ATTACH DOCUMENTS**

State: _____ Year: _____

Circumstances: _____

DISCIPLINARY CHARGES OR ACTION (QUESTION 4) - ATTACH DOCUMENTS

Name of Organization Involved: _____ Date: _____

Duration: _____

Action Taken (circle all that apply):

- | | |
|---|---|
| 01 Revocation of right or privilege | 12 Leave of absence |
| 02 Suspension of right or privilege | 13 Withdrawal of an application |
| 03 Censure | 14 Termination or non-renewal of contract |
| 04 Written reprimand or admonition | 15 Medical Records Suspension |
| 05 Restriction of right or privilege | 16 Probation |
| 06 Non-renewal of right or privilege | 17 Assurance of Discontinuance |
| 07 Fine | 18 Consent Agreement |
| 08 Required performance of public service | 19 Letter of Agreement |
| 09 Education/Training/Counseling/Monitoring | 20 Expulsion from Membership |
| 10 Denial or right or privilege | 21 Reprimand |
| 11 Resignation | 22 Other Specify: _____ |

Circumstances: _____

INVESTIGATION BY ANY OTHER LICENSING BOARD (QUESTION 5) - ATTACH DOCUMENTS

Name of Licensing Board: _____ Date: _____

Location of Licensing Board: _____

Circumstances: _____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE FIVE OF SEVEN

DENIAL OF EXAMINATION PRIVILEGES (QUESTION 6) ATTACH DOCUMENTS

State: _____ Year: _____

Circumstances under which examination privileges denied:

RESIDENCY TRAINING PROGRAM(S) NOT COMPLETED - DISCONTINUED EDUCATION, TRAINING, PRACTICE (QUESTIONS 7 & 8) - ATTACH DOCUMENTS

Residency Training Program(s): _____

Location of Program(s): _____ Year: _____

Circumstances: _____

AFFECTING HEALTH CARE INSTITUTION STAFF PRIVILEGES, EMPLOYMENT OR APPOINTMENT (QUESTION 9)- ATTACH DOCUMENTS

Institution Involved: _____

Location: _____ Date: _____

Circumstances: _____

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

Third Party Payer: _____ Year: _____

Circumstances: _____

CONFIRMED QUALITY CONCERN NOTICE BY PEER REVIEW ORGANIZATION (PRO) (QUESTION 11) ATTACH DOCUMENTS

PRO: _____ Year: _____

Location of PRO: _____

Circumstances: _____

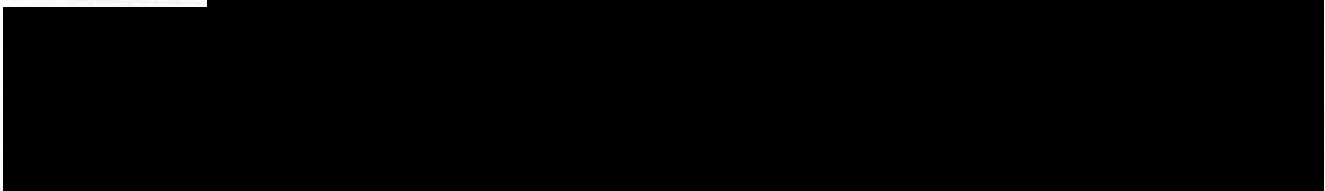
TO RESPOND TO QUESTION 12 SEE PAGE ONE OF THIS FORM

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION, PAGE SIX OF SEVEN

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

Malpractice Insurance Carrier: _____ Year: _____

Circumstances: _____



PRIVILEGE TO PRESCRIBE CONTROLLED SUBSTANCES (QUESTION 14) - ATTACH DOCUMENTS

Name of Organization Involved: _____

Type of Restriction: _____ Date: _____

Circumstances of restriction: _____

CRIMINAL INVESTIGATION - PROCEEDING (QUESTIONS 15 AND 16) - ATTACH DOCUMENTS

Court: _____

City and State: _____

Charge: _____

Date: _____

Description: _____

Status: _____

Conviction?: _____ Date: _____

Plea?: _____ Date: _____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
FORM A CONTINUED - 1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION
PAGE SEVEN OF SEVEN

MEDICAL CONDITION, TREATMENT, USE OF CHEMICAL OR ILLEGAL SUBSTANCES (QUESTIONS 17,18,19, 20, 21, 22, 23, & 24)

Treating Organization: _____

Address: _____

Telephone: (_____) _____

Person Responsible for Treatment: _____

Type of Diagnosis, Condition or Treatment - Field of Practice - Use of Chemical Substances: _____

Dates of Illness or Dependency: _____ to _____

Dates of Treatment: _____ to _____

Name and Location of Rehabilitation/Professional Assistance or Monitoring Program: _____

Telephone: (_____) _____

Contact Person at Program: _____

MEDICAL CONDITION, TREATMENT, USE OF CHEMICAL OR LEGAL SUBSTANCES (QUESTIONS 12-14) (SEE INSTRUCTIONS)

12. Current Condition _____
13. _____
14. _____

15. _____
16. _____
17. _____

18. Telephone () _____
19. Person Responsible for Treatment _____
20. Type of Diagnosis, Condition or Treatment - List of All _____ of Physical Substances _____

21. _____
22. _____
23. _____

24. _____
25. _____
26. _____

27. _____
28. _____
29. _____

30. _____
31. _____
32. _____

33. _____
34. _____
35. _____

36. _____
37. _____
38. _____

39. _____
40. _____
41. _____

42. Name and Address of Rehabilitation Hospital and Program _____
43. Telephone () _____

44. _____
45. _____
46. Contact Person at Program _____

0442-00000417
Philip F. Waterman II, MD
650 Del Prado Blvd, Suite 1000
Cape Coral, FL 33990

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE - SECTION III
1998-2000 PHYSICIAN LICENSE RENEWAL APPLICATION - PAGE FIVE OF FIVE
STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS
Applicant's Statement Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

1. You must check one of the two statements below regarding child support regardless whether or not you have children:

I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.

or

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

Applicant's Statement Regarding Taxes

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

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

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

or

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

Applicant's Statement Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. You must check one of the two statements below regarding unemployment contributions or payments in lieu of unemployment contributions:

I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a \$10,000.00 fine or both).

or

I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.

Social Security # _____

Date of Birth _____

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

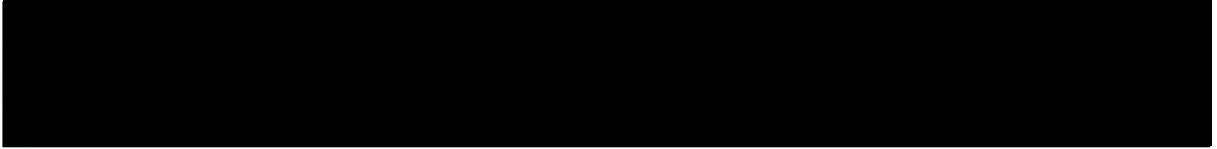
STATEMENT OF APPLICANT

I certify that the information stated by me in this application is true and accurate to the best of my knowledge. I understand that providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

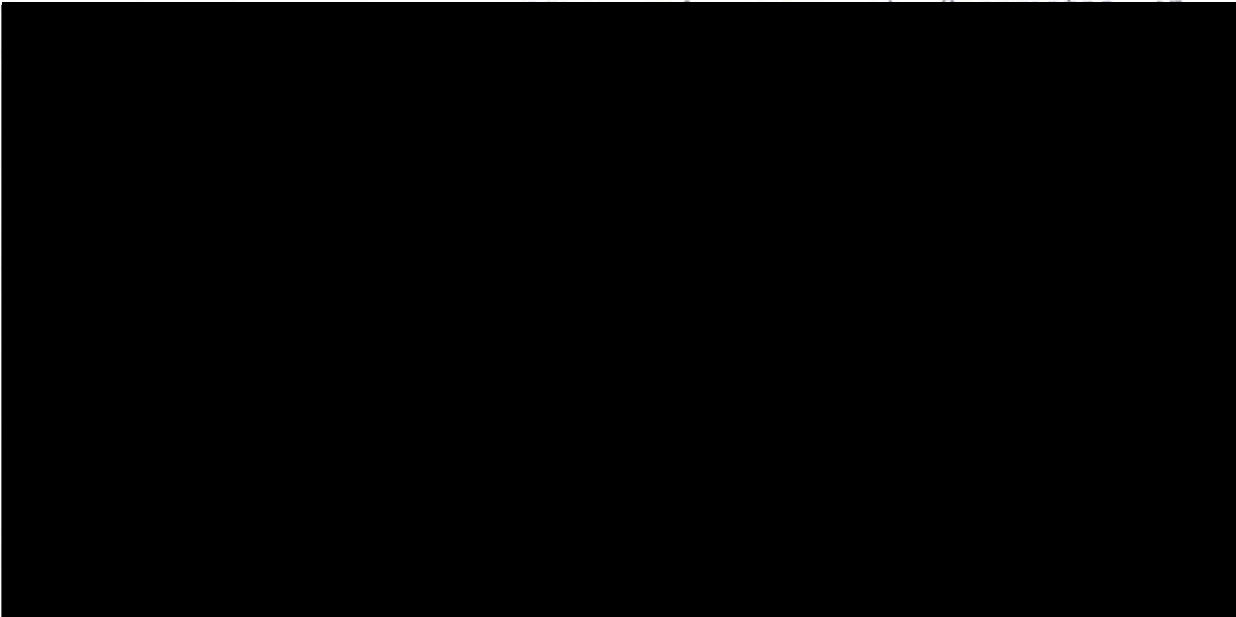
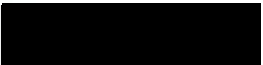
Signature of Applicant _____

Date 10/6/98

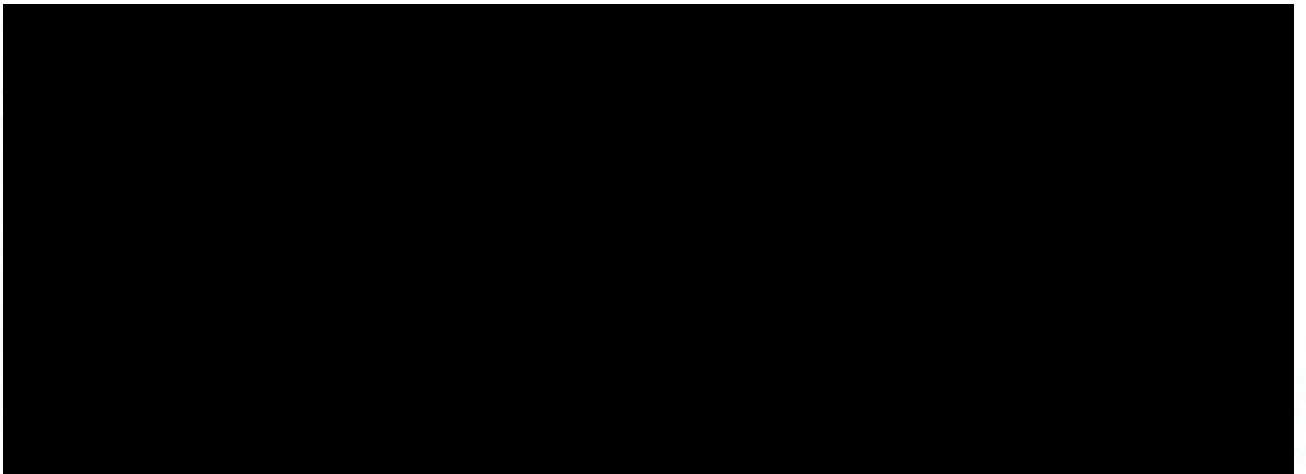
PHILIP F. WATERMAN II, M.D.



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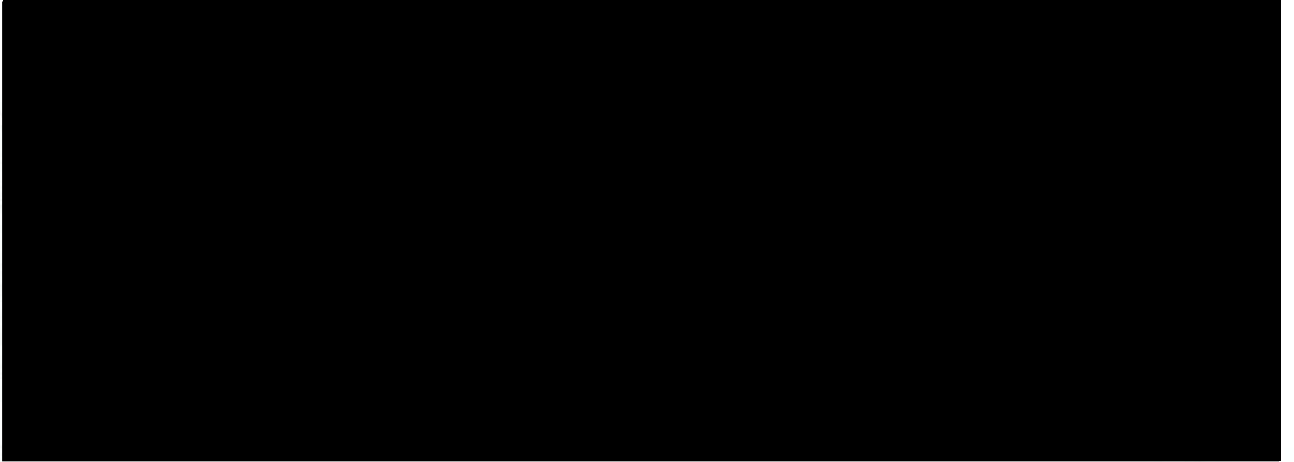
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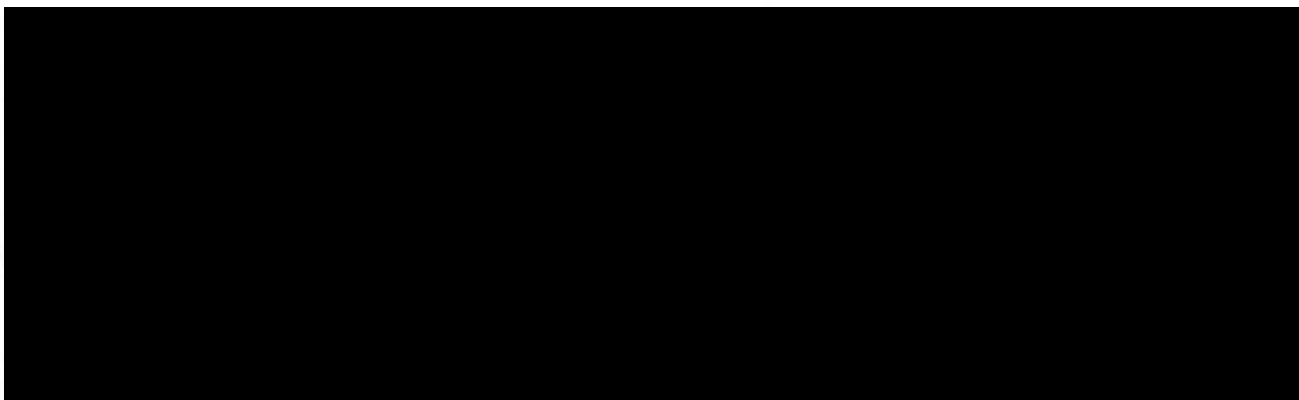
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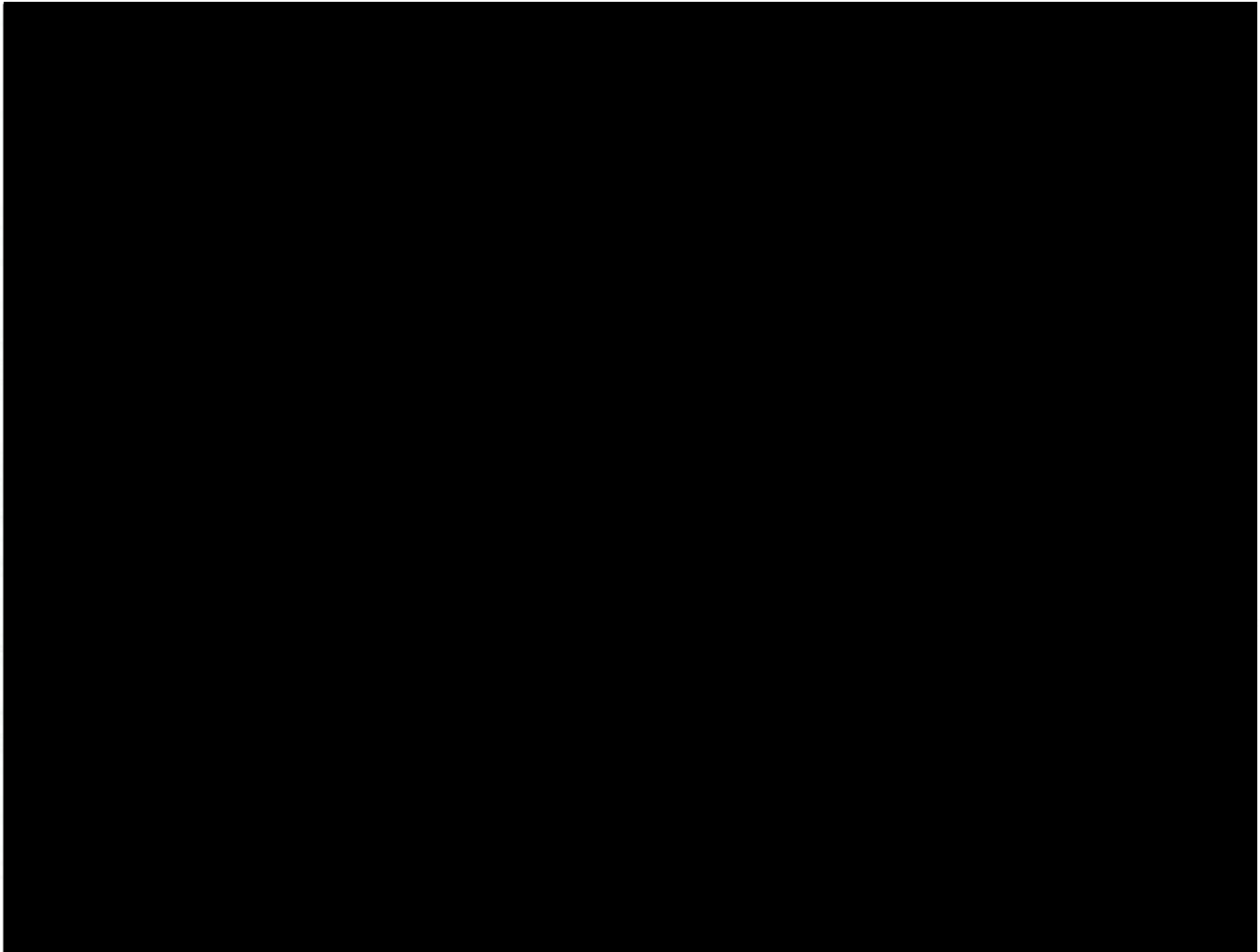
PHILIP F. WATERMAN II, M.D.



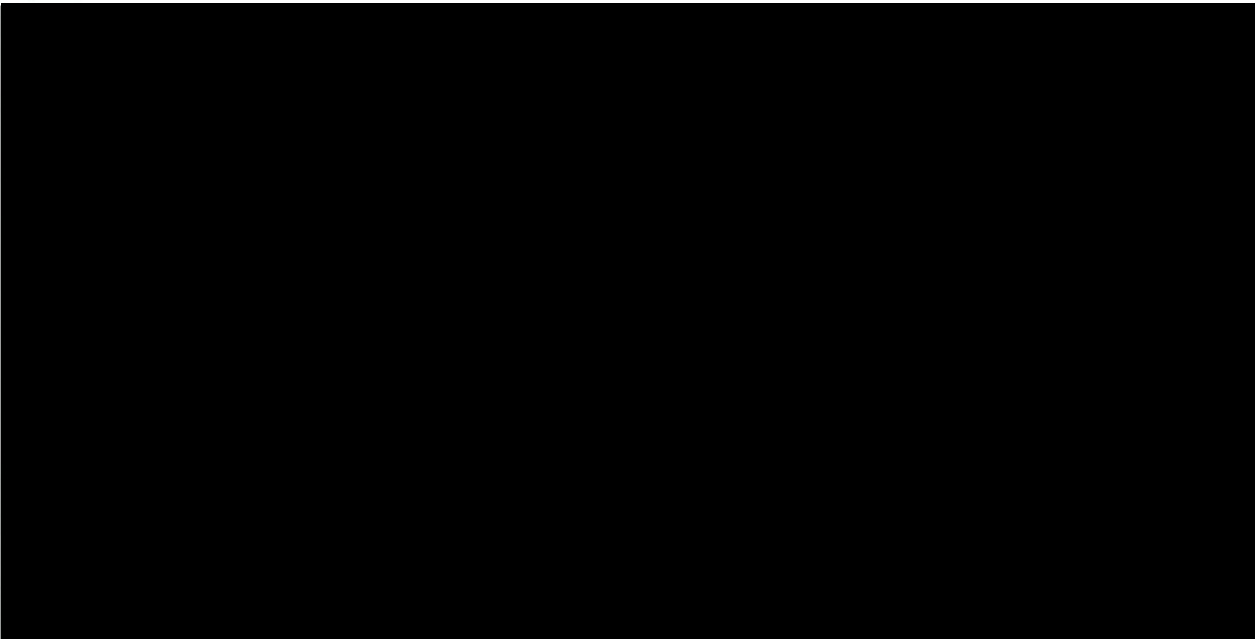
PHILIP F. WATERMAN II, M.D.



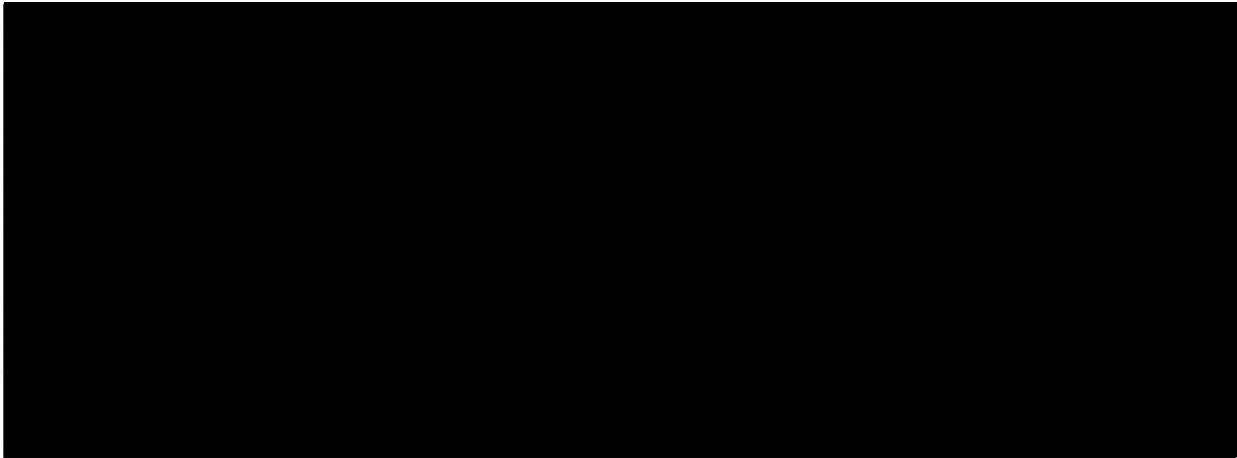
PHILIP F. WATERMAN II, M.D.

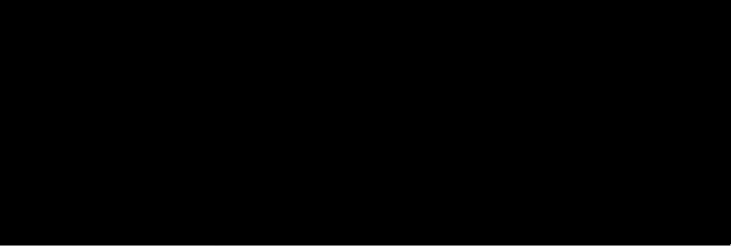


PHILIP F. WATERMAN II, M.D.



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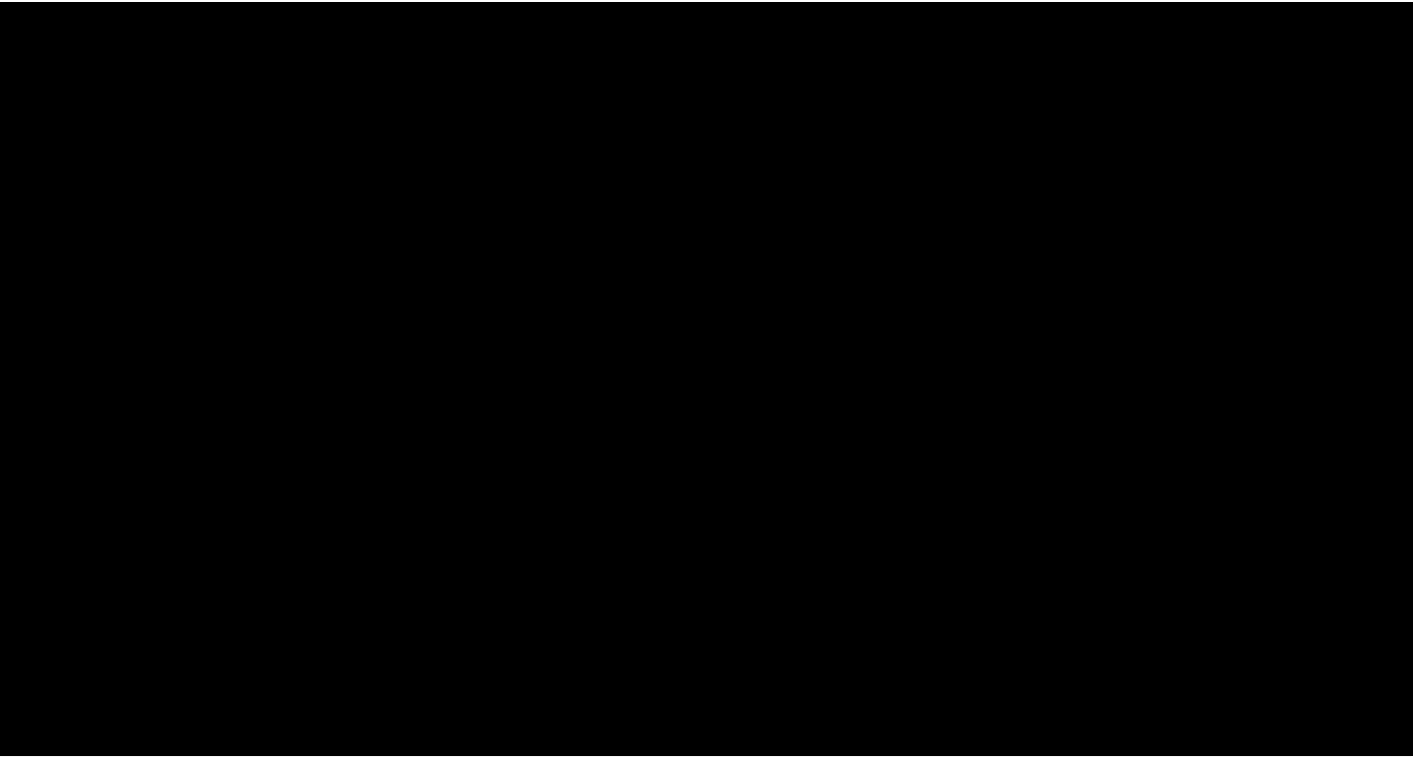


December 21, 1995

Philip F. Waterman, II, M.D.
650 Del Prado Road, Suite 100
Cape Coral, Florida 339909

Re: 

Dear Dr. Waterman:



D (9/88)