1014 $400 6

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070
802 657-4220 or 800-745-7371

2004 PHYSICIAN'S LICENSE RENEWAL APPLICATION

PART I

1. **Your legal name:** Lister, Joan E

Last Name First Name Middle Name Suffix

a. Have you ever legally changed your name? ___Yes _✓_No

If yes, enter your former name and any other name(s) under which you were licensed in Vermont or elsewhere in the past two years;

Last Name First Name Middle Name: Suffix

b. Indicate your name, as it should appear on your license:
LISTER JOAN E
Last Name First Name Middle Name: Suffix

2. **Your Date of Birth:** [redacted]
Month / Day /Year

3. **Home Address:**
15 HAWTHORNE COURT
(Street)
WILLIAMSTOWN MA 01267
(City) (State) (Zip)

4. **Work Address:**
Williamstown Medical Associates
197 Adams Road
WILLIAMSTOWN, MA 01267
(Street)
(City) (State) (Zip)

5. **Please check your preferred mailing address:** ____ Home _✓_ Work
NOTE: ***The mailing address will be publicly listed on the Board's web site.***

6. **Home Telephone Number with Area Code:** (413) 458-2691

7. Work Telephone Number with Area Code: (413) 458-8182

8. E-mail address:

Please check here if the Department of Health may use this e-mail address to send you public health information.
□ yes □ no

PART II

9. Were you in active practice in Vermont in the past 12 Months? □ yes ☑ no

10. Do you hold, or have you ever held, a medical license in any other state? ☑ yes □ no
If yes, complete the section below and attach additional pages if necessary.

MA 1978

State	License Number	Type of License	Date Issued	Status (Active or Inactive)
MA	43434	MD	9/21/78	ACTIVE

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED ON THE ENCLOSED FORM A.

11. Have you ever applied for and been denied a license to practice medicine or any other healing art?
□ yes ☑ no

12. Have you ever withdrawn an application for a license to practice medicine or any other healing art?
□ yes ☑ no

13. Have you ever voluntarily suspended, surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action?
□ yes ☑ no

14. 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

15. Have you ever been denied the privilege of taking an examination before any state medical examining board?
□ yes ☑ no

16. Have you ever discontinued your education, training, or practice for a period of more than three months for reasons other than a family need?
□ yes ☑ no

17. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
□ yes ☑ no

18. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?

☐ yes ☒ no

19. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?

☐ yes ☒ no

20. Are you presently or have you ever been a defendant in a criminal proceeding?

☐ yes ☒ no

PART III

(Unless otherwise ordered by a court, your responses to the questions in Part III are considered exempt from public disclosure.)

PART IV

The following questions are required by Vermont law, 26 VSA § 1368, to update and maintain a data repository within the Department of Health and to make individual profiles on all health care professionals licensed, certified, or registered by the Department available to the public. Your physician profile is located at the following website http://healthyvermonters.com/bmp/mbsearchform.shtml.

Please include photocopies of court papers, licensing authority decisions, and any other relevant documents if your answers to questions 26 through 31 have changed since your last application. We cannot process your application without them.

26. **Criminal Convictions** [26 VSA § 1368(a)(1)] ☑ Check here if none

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past ten years not listed below. **Please provide complete copies of documentation for each matter.**

None reported

(Conviction Date)	(Court)	(City/State)	(Crime

27. **Nolo Contendere/Matters Continued** [26 VSA § 1368(a)(2)] ☑ Check here if none

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction not listed below. **Please provide complete copies of documentation for each matter.**

None reported

(Conviction Date) (Court) (City/State) (Charge)

28. **Vermont Board of Medical Practice Matters** [26 VSA § 1368(a)(3)] ☑ Check here if none

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.
None reported

(Date) (Final Disposition - Summary)

29. **Licensing or Certification Authority Matters in Other States** [26 VSA § 1368(a)(4)]
☑ Check here if none

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states, if not listed below. **Please provide complete copies of documentation for each matter.**
None reported

(Date of Final Disposition) (Licensing or Certification Authority) (Court) (City/State) (Nature of Charge)

30. **Restriction of Hospital Privileges** [26 VSA § 1368(a)(5)]

A. **Revocation/Involuntary Restrictions** ☑ Check here if none

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you if not listed below. **Please provide complete copies of documentation for each matter.**

(Date) (Hospital) (State) (Nature of Restriction) (Reason for Restriction)

B. **Other Restrictions** ☑ Check here if none

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital if not listed below. **Please provide complete copies of documentation for each matter.**

(Date) (Hospital) (State)

(Nature of Action) (Action)

In lieu In settlement

(Reason for Action)

31. **Medical Malpractice Court Judgments/Settlements** [26 VSA § 1368(a)(6A)]

A. **Judgments** ☑ Check here if none

Please complete the attached Form A and provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

Judgement Arbitration
None reported

(Date) (Court) (State) (Nature of Case) (Amount Assessed Against You)

B. **Settlements** ☑ Check here if none

Please provide a description of all settlements of medical malpractice claims against you within the past 10 years (10 years from payment date) in which a payment was awarded to a complaining party if not listed below. **Please provide complete copies of documentation, to include final disposition and, if possible, a copy of the complaint for each matter.**

(Date) (Court) (State) (Amount of Settlement Against You)

32. **Medical Professional Schools** [26 VSA § 1368(a)(7)]

Please provide the names of medical professional schools you attended and the dates of graduation if not listed below.

Tufts University, Boston

5/22/1977

(School/Institution) (City) (State) (Year of Graduation)

If necessary, please use an additional sheet and check this box: .....☐

33. **Graduate Medical Education/Residency** [26 VSA § 1368(a)(8)]

Please provide information about any graduate medical education/residency attended or completed that is not listed below.

Case Western Reserve ,OH

Obstetrics & Gynecology

1978

Tufts ,MA

Obstetrics & Gynecology

1982

(School/Institution) (Specialty) (City) (State) (Year of Graduation)

If necessary, please use an additional sheet and check this box: .....☐

34. **Specialty Board Certification** [26 VSA § 1368(a)(9)]

Please verify the following information regarding your specialty board certification and update as necessary using the attached Specialty Codes List.

Obstetrics and Gynecology
American Board of Obstetrics and Gynecology
1985

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
		☐ yes ☐ no			
		☐ yes ☐ no			

35. **Years of Practice** [26 VSA § 1368(a)(10)]

Month and year you started practicing as a physician?

7/77

36. **Hospital Privileges** [26 VSA § 1368(a)(11)] ☐ Check here if none

List all information for all hospitals where you currently have hospital staff privileges if not listed below:

Nroth Adams Regional

North Adams, MA

(1988-)

(Name) (City) (State) (Year Started)

37. **Appointments/Teaching** [26 VSA § 1368(a)(12)]

Note: Answering #37 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

A. Appointments ☑ Check here if none

Please provide information about your appointments to medical school or professional school faculties if not listed.

None reported

(School) (City) (State) (Nature of Appointment) From (year) To (year)

B. Teaching ☑ Check here if none

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years if not listed.

None reported

(School/Institution) (City) (State) (Nature of Teaching) From (year) To (year)

38. **Publications:** [26 VSA § 1368(a)(13)] ☑ Check here if none

Note: Answering #36 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years if not listed.

(Title) (Publication) (Year)

39. **Activities** [26 VSA § 1368(a)(14)] ☑ Check here if none

Note: Answering #39 is optional. By answering, you are granting permission to have this information posted on the web, ***exactly as provided to the Board.***

Please provide information regarding your professional or community service activities and awards if not listed.

None reported

(Activities or Awards)

40. **Practice Setting** [26 VSA § 1368(a)(15)] ☐ Check here if none

What is the location of your primary practice setting?

Williamstown MA

Town or City State

41. **Translating Services** [26 VSA § 1368(a)(16)] ☑ Check here if none

Please identify any translating services available at your primary practice location.
Are any translating services available at your primary practice location? ☐ Not applicable

If yes, please describe here the translating services available:

None

If necessary, please use an additional sheet and check this box: .....☐

42. **Medicaid/New Patients** [26 VSA § 1368(a)(17)]

A. **Medicaid participation**

Do you participate in the Medicaid program? ☑ yes ☐ no ☐ not applicable

B. **New Medicaid Patients**

Are you currently accepting new Medicaid patients? ☑ yes ☐ no ☐ not applicable

Part V

I hereby affirm that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date: 10/28/04 Jane Smith MD

Applicant's Signature

Reminder - You must also complete the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions regardless of whether or not you have children

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

(Questions 11 and 12) Withdrawal or denial of License - Attach documents

State_____ Year_____
Circumstances under which license was withdrawn, denied, revoked, not renewed, or otherwise terminated_____

(Question 13) Voluntarily surrendered or resigned a license to practice medicine or any healing art - Attach documents

State_____ Year_____

Circumstances N/A

(Question 14) Disciplinary charges or action - Attach documents

Name of organization involved_____ Date_____

Duration_____

Action taken (circle all that apply)

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

Circumstances_____

(Question 15) Denial of examination privileges - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied N/A

(Questions 16 and 17) Residency Training Program(s) not completed - discontinued education, training, practice - Attach documents

Residency Training Program(s) _____

Location of Programs N/A Year _____

Circumstances _____

_____

(Question 18) Affecting Health Care Institution Staff Privileges, Employment or Appointment - Attach documents

Institution involved _____

Location N/A Year _____

Circumstances _____

_____

(Question 19) Privilege to prescribe controlled substances - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

N/A

(Questions 20 and 22) Criminal Investigation - Proceeding - Attach documents

Court _____

City and State _____

Charge _____

Description _____

N/A

Status _____

_____

Conviction? _____ Yes _____ No Date _____

(Question 31) Medical Malpractice Claim

Please provide the following information regarding each instance of alleged malpractice. N/A This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.

Insurer _____

Claimant name _____

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

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;
4. Your degree of responsibility for the course of treatment in leading to the claim; and
5. Narrative of event.

_____

_____

_____

_____

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

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

Your Legal Representative in this matter (include name, address and telephone number)

Name _____

Firm _____

Address _____

City, State, Zip _____

Phone _____

Indicate Decision, Appeal, Settlement, Dismissal:
If a Court or Arbitration Panel heard your case, indicate the following:

N/A

Court _____

Court's location _____

Docket number _____

Date the action was filed _____

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: (month, day, year) ____/____/____

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:

Vermont Department of Health - Board of Medical Practice
APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

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 dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

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

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

☑ I hereby certify, under the pains and penalties or 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".

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 three 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.

or

☐ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* [redacted] Date of Birth [redacted]

* The disclosure of your social security number is mandatory, it 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 Vermont 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 and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant [signature] Date 10/28/04

BULKLEY, RICHARDSON AND GELINAS

LAW OFFICES
1500 MAIN STREET, SUITE 2700
POST OFFICE BOX 15507
SPRINGFIELD, MA 01115-5507

TEL: (413) 781-2820
FAX: (413) 272-6803
E-MAIL: INFO@BULKLEY.COM

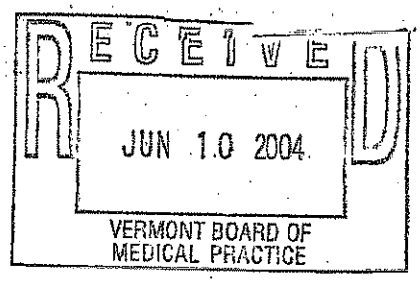
ROBERT B ATKINSON
ROBERT A. GELINAS
STEPHEN W SCHUPACK
PETER ROTH
RONALD F WEISS
FRANCIS D DIBBLE, JR
HAMILTON DOHERTY, JR
MICHAEL H. BURKE
PETER H BARRY
DAVID A. PARKE
FELICITY HARDEE
CHRISTOPHER E MYHRUM
GEORGE W MARION
ELLEN M RANDLE
KEVIN C MAYNARD
MARK D CRESS

Re: Dr Joan Lister, was on 6/2/04 Lic. Comm. agenda. Peggy Bree

June 9, 2004

Via Facsimile (802) 951-1275

Bill Wargo, Esquire, Legal Counsel
Board of Medical Practice
Department of Health
P.O. Box 70
Burlington, VT 05402



Re: Joan E. Lister, M.D.

Dear Mr. Wargo:

Pursuant to your request, this letter serves to provide information to you regarding the matter of *Maria C. Leal and Manuel A. Leal vs. Northern Berkshire Ob-Gyn, Inc., Bonnie H. Herr, M.D. and Joan E. Lister, M.D.*, Berkshire Superior Court, Civil Action No. BECV1999-00176.

This matter was tried before a jury in Berkshire Superior Court in August 2003 with a defense verdict for all defendants.

Should you need further information regarding this claim, please do not hesitate to contact me.

Very truly yours,

Melinda M. Phelps

MMP/jsf

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070

APPLICATION FOR LICENSE TO PRACTICE MEDICINE IN VERMONT
PHYSICIAN - MEDICAL DOCTOR

I hereby apply for LICENSURE AS A PHYSICIAN in the state of Vermont.

Instructions

- *Please enclose a check in the amount of $400 payable to the Vermont Department of Health.*
- *Please print legibly or type your answers. Please type or print in block letters, one letter (or digit) in each box.*
- *Answer all questions completely.*
- *Use the enclosed Form A to provide explanations to "yes" answers in Parts III and IV.*
- *Please be sure to write your name on each attachment.*
- *Please be sure to complete the Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions.*
- *Make a copy of the completed form and all attachments for your own records.*
- *Do not delegate this important task to an employee. False statements on this form are grounds for findings of unprofessional conduct.*

Part I - Identity Questions

1. Print your full name as you wish it to appear on the license:

First name: Joan

Middle name: Elizabeth

Last name: Lister

Extension:

RECEIVED
NOV 17 2009
VERMONT BOARD OF MEDICAL PRACTICE

2. Have you ever legally changed your name? ☐ Yes ☑ No
If yes, enclose a certified copy of the legal document stating the change.

*Name as it should appear on your license: _____

Other Name(s), if any, under which you were licensed elsewhere: _____

3. Your date of birth: M M D D Y Y Y Y [redacted]

4: Your mailing address: (Check one: Home address Work address)

Care of: Williamstown Medical Assoc.

Street: 197 Adams Road

Town/City: Williamstown

State: MA

Zip Code: 01267-2930

5. Your electronic addresses:

Home telephone (optional): ___ - ___ - ____ example: 802-555-1212

Work telephone: 413 - 458 - 8182 x

E-mail (optional):

6. Were you in active practice in Vermont in the past 12 Months? ☐ Yes ☑ No

7. Have you ever held a Vermont Limited Temporary License? ☐ Yes ☑ No
If yes, License Number _____

8. 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 (M M D D Y Y Y Y)	Status (Active, inactive, other)
MA	43434	09/21/1978	Active

If necessary, please use an additional sheet and check this box: .....

Part II – Education, Training, Practice and Examinations

9. Premedical Education

Please provide the names of premedical schools you attended and the dates of attendance.

Name and location of institution	Degree	From	To
Wellesley College Wellesley, MA	B.A.	09/67	05/71
Wellesley College Wellesley, MA	pre-med	09/71	05/73

If necessary, please use an additional sheet and check this box: .....

10. Medical Professional Schools - See enclosed Certificate of Medical Education

Please provide the names of medical professional schools you attended and the dates of attendance. ***Note: This information should be provided in the Statutory Profile Section (Part V #36)***

11. Graduate Medical Education

Please provide the names of graduate medical schools you attended and the dates of attendance.

Note: This information should be provided in the Statutory Profile Section (Part V #37)

12. Examinations

A. USMLE or FLEX Examination

Have you ever taken the USMLE or FLEX examination? ☐ Yes ☑ No

If yes, have a Certified Copy of your results forwarded to this office by the Federation of State Medical Board.

B. National Boards

Have you ever taken the National Boards? ☑ Yes ☐ No

If yes, have a Certified Copy of your results forwarded to this office by the National Board of Medical Examiners.

C. State Examination

Have you ever taken a State Medical Board Examination? ☐ Yes ☑ No

If yes, make sure that the scores are included on the Certificate of Medical Licensure to be sent to that Board (see enclosed Certificate of Medical Licensure).

13. International Medical Graduates

*boxes

A. ECFMG Standard Certificate Number: _____ Date issued: _____

B. Direct verification of your ECFMG Certificate must accompany this application. (See enclosed request form)

C. Are you a graduate of a fifth pathway program: ☐ Yes ☑ No

If yes, direct verification of your fifth pathway certificate must accompany this application.

14. 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
North Adams Regional	North Adams, MA	1988-present	OB/GYN

Part III - Licensure and Practice Questions

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

15. Have you ever applied for and been denied a license to practice medicine or any other healing art?
☐ Yes ☑ No

16. Have you ever withdrawn an application for a license to practice medicine or any other healing art?
☐ Yes ☑ No

17. Have you ever voluntarily surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action?
☐ Yes ☑ No

18. Are any formal disciplinary charges pending against you by any governmental authority, hospital or health care facility, or professional medical association?
☐ Yes ☑ No

19. Have you ever been denied the privilege of taking an examination before any state medical examining board?
☐ Yes ☑ No

20. Have you ever discontinued your education, training, or practice for a period of more than three months for reasons other than a family need?
☐ Yes ☑ No

21. Have you ever been dismissed or suspended from, or asked to leave a residency training program before completion?
☐ Yes ☑ No

22. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted?
☐ Yes ☑ No

23. Are you presently a defendant in a criminal proceeding?
☐ Yes ☑ No

24. To your knowledge, are you presently named in a malpractice action that has not been resolved (i.e., has not been either dismissed or settled)?
☐ Yes ☑ No

Part IV - Confidential Section

Part IV is exempt from public disclosure

Part V - Statutory Profile Questions

Vermont law, 26 VSA § 1368, creates a data repository within the Department of Health. Under this law, the Department must collect certain information to create individual profiles on all health care professionals licensed, certified, or registered by the Department pursuant to Title 26 of the VSA. Please answer the following questions to the best of your ability. You will receive a copy of your profile prior to its initial release to the public and each time the profile is modified or amended. You will be given a reasonable time to correct factual inaccuracies that appear in such profile. As noted below, certain questions do not need to be answered.

It is very important for us to receive photostatic copies of court papers, licensing authority decisions, and other documents relevant to the questions below in order to have a true and accurate description of the actions taken.

30. **Criminal Convictions** [See 26 VSA § 1368(a)(1)]

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted within the past 10 years. For purposes of this question, "convicted" means that you pleaded guilty or that you were found or adjudged guilty by a court of competent jurisdiction. **Please provide copies of papers fully documenting the convictions.**

Conviction Date M M	D D	Y Y Y Y	Court	City	State	Crime

If necessary, please use an additional sheet and check this box: .....

31. **Nolo Contendere/Matters Continued** [See 26 VSA § 1368(a)(2)]

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction. **Please provide copies of papers fully documenting these matters.**

Date M M	D D	Y Y Y Y	Court	City	State	Charge	Nature of Action
							Nolo Contendere Matter Continued
							Nolo Contendere Matter Continued

													Nolo Contendere
[redacted]										[redacted]			Matter Continued

If necessary, please use an additional sheet and check this box: ......

32. **Vermont Board of Medical Practice Matters** [See 26 VSA § 1368(a)(3)]

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed, within the past 10 years. (We will have the documentation on file; we are asking you to provide the description.)

Date M	M	D	D	Y	Y	Y	Y	Final Disposition (Summary)

If necessary, please use an additional sheet and check this box: ......

33. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]

Please provide a description of all formal charges served by licensing authorities of other states, the findings, conclusions, and orders of such licensing authorities, and final disposition of such matters by the courts, if appealed, in those states within the past 10 years. **Please provide copies of papers fully documenting these matters.**

Date of Final Disposition M	M	D	D	Y	Y	Y	Y	Licensing Authority	Court	City	State		Nature of Charges

If necessary, please use an additional sheet and check this box: ......

34. **Restriction of Hospital Privileges** [See 26 VSA § 1368(a)(5)]

A. Revocation/Involuntary Restrictions

Please provide a description of any revocation or involuntary restriction of your hospital privileges within the past 10 years that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. **Please provide copies of papers fully documenting these matters.**

Date M	M	D	D	Y	Y	Y	Y	Hospital	State		Nature of Restriction	Reason for Restriction

If necessary, please use an additional sheet and check this box: .....

B. **Other Restrictions**

Please provide a description of all resignations from, or nonrenewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital within the past 10 years. **Please provide copies of papers fully documenting these matters.**

Date M M D D Y Y Y Y	Hospital	State	Nature of Action	Action	Reason for Action
				In Lieu of In Settlement	
				In Lieu of In Settlement	
				In Lieu of In Settlement	

If necessary, please use an additional sheet and check this box: .....

35. **Medical Malpractice Court Judgments/Settlements** [See 26 VSA § 1368(a)(6A)]

A. **Judgments**

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you within the past 10 years in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**

Date M M D D Y Y Y Y	Court	State	Nature of Case	Amount Assessed Against You
			Judgment Arbitration	
			Judgment Arbitration	
			Judgment Arbitration	

If necessary, please use an additional sheet and check this box: .....

B. **Settlements**

Please provide a description of all settlements of medical malpractice claims against you within the past 10 years in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**

Date M M	D D	Y Y Y Y	Court	State	Amount of Settlement Against You

If necessary, please use an additional sheet and check this box: .....

36. **Medical Professional Schools** [See 26 VSA § 1368(a)(7)]

Please provide the name, location, dates of attendance of medical schools attended.

School	City	State	Year of Graduation
Tufts University	Boston	MA	1977

If necessary, please use an additional sheet and check this box: .....

37. **Graduate Medical Education** [See 26 VSA § 1368(a)(8)]

List chronologically residency or other graduate training. Give names, addresses of hospitals, dates (month, day, year) and type of training. Include copies of Certificate of Attendance.

*Name Address From/To Training

	School/Institution	Specialty	City	State	Year of Graduation
Internship	Case-Western Reserve Univ	OB+GYN	Cleveland	OH	1978
Residency	Tufts Affiliated Hospitals	OB+GYN	Boston	MA	1982

If necessary, please use an additional sheet and check this box: .....

38. **Specialty Board Certification** [See 26 VSA § 1368(a)(9)]

Enter up to three specialty codes from the enclosed ***Specialty Codes List***. List your primary specialty first. If you cannot locate a specialty, please write the specialty name in the space provided.

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
1101		(yes) no	American Board of OB/GYN	1985	
		yes no			
		yes no			

39. **Years of Practice** [See 26 VSA § 1368(a)(10)]

A. What month and year did you start the practice of medicine (excluding residency/fellowship training)?

M	M	Y	Y	Y	Y
0	9	1	9	8	2

B.. List all hospitals where you previously have had staff privileges. Include name, address and include dated.

*Name Address From/To Specialty/SubSpecialty

Name	City	State	Year Started	
Brigham + Women's Hospital	Boston	MA	1982	- 1984

If necessary, please use an additional sheet and check this box: .....

40. **Hospital Privileges** [See 26 VSA § 1368(a)(11)]

List all hospitals where you currently have hospital staff privileges:

Name	City	State	Year Started	
North Adams Regional	North Adams	MA	1984	- present

If necessary, please use an additional sheet and check this box: .....

41. **Appointments/Teaching** [See 26 VSA § 1368(a)(12)] Note: Answering #41 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. **Appointments**

Please provide information about your appointments to medical school or professional school faculties.

School	City	State	Nature of Appointment	From (year)	To (year)

If necessary, please use an additional sheet and check this box: .....

B. **Teaching**

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years.

School/Institution	City	State	Nature of Teaching	From (year)	To (year)

If necessary, please use an additional sheet and check this box: .....

42. **Publications** [See 26 VSA § 1368(a)(13)] Note: Answering #42 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

Title	Publication	Year

If necessary, please use an additional sheet and check this box: .....

43. **Activities** [See 26 VSA § 1368(a)(14)] Note: Answering #43 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your professional or community service activities and awards.

Activities or Awards

If necessary, please use an additional sheet and check this box: .....

End of Statutory Profile Questions

44. **Interview**

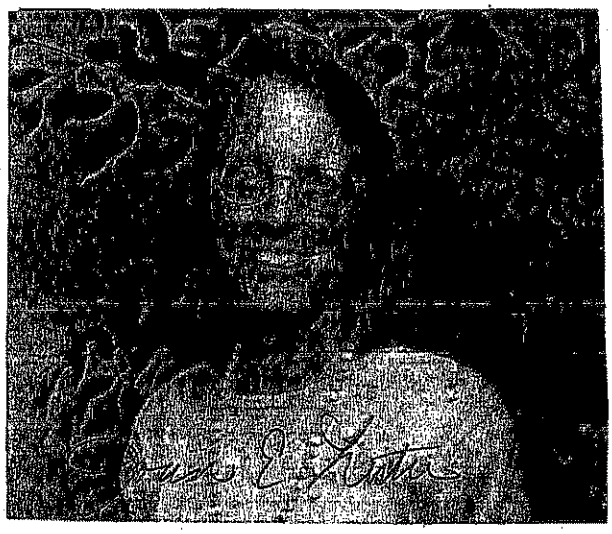
A. In which part of Vermont would you prefer to be interviewed? (Northern - Burlington area, Southern - Springfield or Rutland areas, Central - Montpelier area)

B. When are you scheduled to begin work in Vermont? Not Yet Scheduled

C. What has been you physical residence (city, state) in the past ten years? Williamstown, MA

Part VI - Photograph

PLEASE PROVIDE A PHOTOGRAPH: Attach a recent photograph (head and shoulders). Please sign the front of the photograph.



Part VII - Signature

Reminder - You must also complete and sign the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions, Form B, and authorizations for release of information as appropriate, Form C.

I hereby aver that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date: 11/30/03

Joan E. Lister
Applicant's Signature

Return completed application to:

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington VT 05402-0070

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES, UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

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 dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

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

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

✓ I hereby certify, under the pains and penalties or 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".

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 three 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.

or

I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* [redacted] Date of Birth [redacted]

* The disclosure of your social security number is mandatory, it 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 Vermont 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 and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant [signature] Date 10/30/03

FORM B

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

FORM B: 1) AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION AND 2) AUTHORIZATION TO COMMUNICATE WITH FUTURE EMPLOYERS REGARDING THE STATUS OF YOUR APPLICATION

TO WHOM IT MAY CONCERN:

1) I, Joan E. Lister, MD, HEREBY AUTHORIZE YOU to furnish to the
(Name of Applicant)

Vermont Board of Medical Practice or its designated representative, all materials and information within your possession or control relating to me, of whatever kind and wherever located and including, but not limited to, my education, my professional experience and qualifications, my licensing history, my practice as a physician, civil and criminal court records, and any other material or information, including investigative files, which, in the sole discretion of the Vermont Board of Medical Practice, may be useful to said Board in its review of my licensing status.

Only in regard to this specific authorization for disclosure to the Vermont Board of Medical Practice and for no other purpose, I expressly WAIVE confidentiality and any privileges or immunities accorded this information by State or Federal Law, and I hold you harmless from disclosure of same to the Vermont Board of Medical Practice.

YOU ARE ALSO AUTHORIZED to report information, either orally or in writing, directly to the Vermont Board of Medical Practice or its designated representative on a continuing basis until this authorization is revoked, by me, in writing.

A CONFORMED PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL SERVE IN ITS STEAD.

2) I further authorize the Vermont Board of Medical Practice to communicate with future employers and/or locum tenens companies regarding the status of my application for licensure.

Signature: Joan E. Lister

Date: 10/30/03

Print or Type Name: Joan E. Lister

Address: 197 Adams Road

City, State, Zip Code: Williamstown MA 01267

Telephone Number: (413) 458-8182

Subscribed and sworn to before me, this 30th day of October, 2003.

Ann M. Rathbun
Notary Public Ann M. Rathbun

Affix Seal

My License Expires: 5/7/04

RETURN ORIGINAL TO THE BOARD WITH YOUR APPLICATION
SEND COPIES WITH THE REFERENCE FORMS

Universitas Tuftensis

in Republica Massachusettensi

Omnibus ad quos hae litterae pervenerint salutem plurimam dicit

Praeses Universitatis Tuftensis

honorandis ac reverendis Curatoribus iubentibus
doctis ac eruditis Professoribus probantibus
Scholae eius quae scientiam medicinae colit

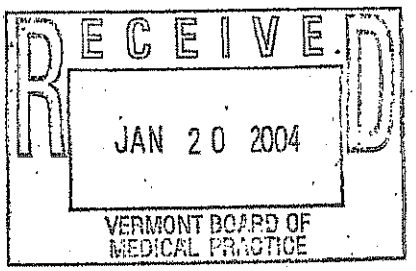
Joan Elizabeth Lister

ad gradum **Medicinae Doctoris** admisit eique
fruenda dedit et concessit omnia iura, honores, insignia, privilegia ad hunc
gradum pertinentia. In cuius rei testimonium litteris hisce Sigillo Academico munitis
ante diem XI Kal. Jun. MCMLXXVII
nos Praeses Universitatis et Decanus Scholae
auctoritate nobis commissa nomina subscripsimus.

Dean

President

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401



CERTIFICATE OF MEDICAL EDUCATION

To be completed by an officer of your School of Medicine

I hereby certify that JOAN E. LISTER (Name) was admitted to the

TUFTS UNIVERSITY School of Medicine

in BOSTON MA (City and State) on 09/05/73 (Date)

and completed all requirements for graduation on 05/20/77 (Date)

A DOCTOR OF MEDICINE (Specify certificate/diploma/degree) was granted on 05/22/77 (Date)

(AFFIX SEAL)

Date: 1/16/04

Signed: Carol A. Dulley
(Authorized Officer of the School of Medicine)

REGISTRAR

Commonwealth of Massachusetts

Board of Registration in Medicine

560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9810
Fax (617) 426-9538

Date: 12/02/2003

To Whom It May Concern:

This is to certify **JOAN E. LISTER, M.D.,** a graduate of **Tufts University School of Medicine** in the year **1977** , has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number **43434** was issued to Dr. LISTER on Sep 21 1978.

THIS LICENSE IS CURRENT. The expiration date is Mar 19 2005.

Our files contain no open complaint information on this physician.

Our files contain no closed complaint information on this physician.

Our files contain no disciplinary information on this physician.

SEAL

Member, Board of Registration in Medicine

Please be advised that the above information is based entirely on examination of our open and closed complaint files, as well as post-1986 disciplinary actions. It is not based on a review of the application for licensure, renewal of licensure, pre-1987 disciplinary actions, or any reports that the Board is required to receive by statute (from courts, insurers, hospitals, etc...).

NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)
Endorsement of Certification

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9592

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

Date: 11/21/2003

Examinee: Joan Elizabeth Lister

Examinee ID:

Date of Birth: [redacted]

NBME Certification Date: 07/01/1978

Certificate#: 184539

It is certified that the physician named above successfully completed the examination, education and training requirements for certification by the NBME as of the certification date shown above. This record shows only passing scores for each NBME Part examination reported on this document. If applicable, results for all USMLE Steps taken by this examinee (and for which scores have been reported to date) are also shown.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores: Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
06/10/1975	Pass	Three-Digit	515	(380)	625	600	400	395	515	485	590
		Two-Digit	81	(75)	88	87	75	75	81	80	86

NBME PART II

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)	Individual Subject Scores: Med	Surg	ObGyn	Prev	Peds	Psych
09/28/1976	Pass	Three-Digit	585	(290)	620	560	555	605	540	530
		Two-Digit	85	(75)	88	85	85	87	84	84

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)
03/08/1978	Pass	Three-Digit	515	(290)
		Two-Digit	82.7	(75)

VT 1250

INTERPRETATION OF SCORES

NBME Part I and Part II Examinations Prior to June 1991
The most recent total test and subject scores are reported. The total test score is based on the total number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are on a scale with a mean of 500 and a standard deviation of 100, in increments of 5. Most scores fall between 250 and 750.

NBME Part I and Part II Examinations June 1991 and Thereafter
The most recent total test score is reported. This score is on a scale with a mean of 200 and a standard deviation of 20, in increments of 1. Most scores fall between 145 and 260.

All NBME Part III Examinations
The most recent total test score is reported. This score is on a scale with a mean of 500 and a standard deviation of 100, in increments of 5. Most scores fall between 250 and 750.

Two-Digit NBME Scores
For all NBME scores, an equivalent value scale score on a two-digit scale is also provided. The scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

USMLE Step 1, Step 2 and Step 3
If applicable, this document will include a complete score history and notations of any USMLE examinations for which the examinee sat and no scores were reported, such as "Incomplete" or "Indeterminate." Scores are reported on two different scales. For each Step, the mean and standard deviation of scores on the three-digit scale for the original anchor group of first-time examinees from medical schools in the United States was 200 and 20, respectively. Most scores fall between 140 and 280. An equivalent value score on a two-digit scale is also provided. A score of 75 on the two-digit scale is the recommended minimum passing score. The recommended minimum passing score on each scale is shown on the front of the transcript next to the examinee's score for each examination administration. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change.

Factors which influence an examinee's score include the examinee's general understanding of the subject matter being tested and the specific set of test items used for an administration. The Standard Error of Measurement (SEM) provides an index of the variation in scores that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM for a USMLE score is usually in the range of 4 to 8 score points on the three-digit scale and 1 to 2 score points on the two-digit scale.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this document may result in one or more annotations listed next to the score. A description of each "Comment" is provided below:

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, unexplained inconsistency of performance within the examination or between administrations of the same Step. **No score is reported.** Information regarding the nature of the indeterminate score and the determination of the Committee on Score Validity is available. If such information is not enclosed with this document, it may be obtained by contacting the NBME or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information.* Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this document, it may be obtained by contacting the NBME or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances <u>not</u> in connection with an administration shown on this document may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The "Note" will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are <u>not</u> disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on this document by a "Note".

State of Massachusetts

County of Berkshire

On this 30th day of October, 2003, I certify that the

preceding/attached document is a true, exact, complete and unaltered photocopy made by

Joan E. Lister MD of her, OB/Gyn Board Certificate

Ann M. Rathbun

Notary Public Ann M. Rathbun

(Seal)

My Commission expires 5/7/04

American Board of Obstetrics and Gynecology

DIPLOMATE

COMPOSED OF MEMBERS NOMINATED BY THE
AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY
AMERICAN MEDICAL ASSOCIATION
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
ASSOCIATION OF PROFESSORS OF GYNECOLOGY OBSTETRICS
CERTIFIES THAT

JOAN E. LISTER

HAVING PURSUED AN ACCEPTED COURSE OF GRADUATE STUDY AND CLINICAL WORK, HAS MET THE STANDARDS AND QUALIFICATIONS AND PASSED THE EXAMINATIONS REQUIRED BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC. SHE HAS THEREBY DEMONSTRATED TO THE SATISFACTION OF THIS BOARD THAT SHE IS POSSESSED OF SPECIAL KNOWLEDGE, AND BY THE AWARD OF THIS DIPLOMA HER PROFICIENCY IN THE SPECIALITY OF OBSTETRICS AND GYNECOLOGY IS RECOGNIZED AND SHE IS AN ACKNOWLEDGED DIPLOMATE OF THIS BOARD

DECEMBER 7, 1984

PRESIDENT

EXECUTIVE DIRECTOR

CHAIRMAN

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

RECEIVED
FEB 9 2004
VERMONT BOARD OF MEDICAL PRACTICE

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

To be completed by the Training Program Director:

Name of Institution: University Hospitals of Cleveland

Address: 11100 Euclid Avenue

Cleveland OH 44106

If name of the Institution was different when applicant attended, please enter name: _____

I hereby certify that Joan E. Lister, MD (Name) was enrolled in the

Residency (Program Type (residency, fellowship))

OBSTETRICS - GYNECOLOGY (Department (e.g. Radiology, Internal Medicine))

at this institution from 7 (Month) / 1 (Day) / 77 (Year) to

6 (Month) / 30 (Day) / 78 (Year).

During the time of the applicant's participation, our postgraduate medical training was accredited by the ACGME. If Canadian Training circle if approved by Royal College of Physicians and Surgeons of Canada.

Our records indicate that the applicant received a certificate of completion on

6 (Month) / 30 (Day) / 78 (Year).

(AFFIX SEAL)

Date: 1/28/04

Signed: _____, M.D.
(Official of the Sponsoring Institution)

Print Name: LASZLO SOGOR, MD, PhD

Title: PROGRAM DIRECTOR

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

To be completed by the Training Program Director:

Name of Institution: Tufts New England Medical Center for (No longer exists St. Margarets Hospital for Women & Children)

Address: 750 Washington Street
NEMC Box #022
Boston, MA 02111

If name of the Institution was different when applicant attended, please enter name: St. Margaret's Hospital for Women

I hereby certify that Joan E. Lister, MD (Name) was enrolled in the Residency in Obstetrics & Gynecology (Program Type (residency, fellowship))

Obstetrics & Gynecology (Department (e.g. Radiology, Internal Medicine))

at this institution from July (Month) 1 (Day) 1979 (Year) to June (Month) 30 (Day) 1982 (Year).

During the time of the applicant's participation, our postgraduate medical training was accredited by the ACGME. If Canadian Training circle if approved by Royal College of Physicians and Surgeons of Canada.

Our records indicate that the applicant received a certificate of completion on June (Month) 30 (Day) 1982 (Year).

(AFFIX SEAL)

Date: February 3, 2004

Signed: Robert D Kennison MD
(Official of the Sponsoring Institution)

Print Name: Robert D. Kennison

Title: Program Director

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VERMONT BOARD OF MEDICAL PRACTICE

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

LIST OF THREE REFERENCES

Detach the attached Reference Forms and send to the individuals designated below* ALONG WITH A COPY OF THE SIGNED FORM B RELEASE. Return this sheet to the Board with your application. Individuals completing the reference forms must return the forms directly to the Board.

*NOTE: Program Director should be substituted for Chief of Service for applicants who are applying for a license while still in residency training or have completed a residency within the last year. (SEE ATTACHED SEPARATE FORM FOR PROGRAM DIRECTOR.)

Names, addresses and telephone numbers of three references:

1) Reference #1 - Chief of Service (See Program Director Note * above): Bonnie H. Hey, MD

Address: 197 Adams Road

City, State, Zip Code: Williamstown, MA 01267

Telephone: (413) 458-8182

How long and in what capacity has this individual known you? 15+ years, partner

2) Reference #2 - Active physician staff member at the hospital where you have a current or recent appointment:

Name: Susan J. Yates MD

Address: 197 Adams Road

City, State, Zip Code: Williamstown, MA 01267

Telephone: (413) 458-8182

How long and in what capacity has this individual known you? 15+ yrs Colleague, now partner

3) Reference #3 - Active physician staff member at the hospital where you have a current or recent appointment:

Name: Charles E O'Neill MD

Address: 197 Adams Road

City, State, Zip Code: Williamstown, MA 01267

Telephone: (413) 458-8182

How long and in what capacity has this individual known you? 15+ years, colleague, now partner

Note: If you are unable to provide references from these individuals because you have never held hospital privileges, attach such an explanation to this form when you submit your application. Three other references from physicians you have worked with most recently will then be required.

Chief of Service Form
Return Directly to Board

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

REFERENCE FORM TO BE COMPLETED BY CHIEF OF SERVICE, PAGE ONE OF TWO

Name of Applicant: Joan E. Lister

The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. **Thank you for your cooperation.**

Please complete all parts of this form. If more room is needed, please attach additional information.

Dr. Lister was at North Adams Regional Hospital from 9/88 to present. During that time, he/she was (List status in the institution): active staff

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

Basic medical knowledge:	___ Poor	___ Fair	___ Average	✓ Above Average
Professional judgment:	___ Poor	___ Fair	___ Average	✓ Above Average
Sense of responsibility	___ Poor	___ Fair	___ Average	✓ Above Average
Moral character/ ethical conduct:	___ Poor	___ Fair	___ Average	✓ Above Average
Competence and skill:	___ Poor	___ Fair	___ Average	✓ Above Average
Cooperativeness, ability to work with others:	___ Poor	___ Fair	___ Average	✓ Above Average
History & physical exam taking:	___ Poor	___ Fair	___ Average	✓ Above Average
Record keeping	___ Poor	___ Fair	___ Average	✓ Above Average
Case presentations:	___ Poor	___ Fair	___ Average	✓ Above Average
Patient management:	___ Poor	___ Fair	___ Average	✓ Above Average
Physician-Patient relationship:	___ Poor	___ Fair	___ Average	✓ Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	___ Poor	___ Fair	___ Average	✓ Above Average
Participation in Medical Staff Affairs	___ Poor	___ Fair	___ Average	✓ Above Average

Chief of Service Form
Continued

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

REFERENCE FORM TO BE COMPLETED BY CHIEF OF SERVICE, PAGE TWO OF TWO

Name of Applicant: Joan E. Lister

How long have you known the applicant and in what capacity? 16 years – She has been my partner x 16 yrs.

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? ✓ Yes ____ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine? ____ Yes ✓ No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? Gijanto case (see application) ✓ Yes ____ No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.) ____ Yes ✓ No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? ____ Yes ✓ No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? ____ Yes ✓ No

Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? ____ Yes ✓ No

Do you know of a failure of the applicant to complete a residency training program(s)? ____ Yes ✓ No

Does the applicant call upon consults when needed? ✓ Yes ____ No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluating this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:
✓ Close personal observation
____ General impression
____ A composite of faculty/staff evaluations
____ Other - Specify: _____

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend Joan E. Lister (Name of Physician) for licensure in Vermont.

Signed: Bonnie H Herr Date: 1/21/04

Print or Type Name and Title: Bonnie H. Herr, M.D.
Chairman – Maternal-Newborn Dept.
North Adams Regional Hospital
N. Adams, MA

Reference Form #2
Return Directly to Board

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

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VERMONT BOARD OF
MEDICAL PRACTICE

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER AT THE HOSPITAL WHERE YOU HAVE A CURRENT OR RECENT APPOINTMENT. PAGE ONE OF TWO

Name of Applicant: Joan E. Lister, MD

The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. **Thank you for your cooperation.**

Please complete all parts of this form. If more room is needed, please attach additional information.

Dr. Joan Lister was at North Adams Regional Hospital from approx 1989 to present. During that time, he/she was (List status in the Institution): active staff - Ob-Gyn, Now gynonly.

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

	Poor	Fair	Average	Above Average
Basic medical knowledge:	___	___	___	✓
Professional judgment:	___	___	___	✓
Sense of responsibility:	___	___	✓	___
Moral character/ ethical conduct:	___	___	___	✓
Competence and skill:	___	___	___	✓
Cooperativeness, ability to work with others:	___	___	✓	___
History & physical exam taking:	___	___	___	✓
Record keeping	___	___	___	✓
Case presentations:	___	___	___	✓
Patient management:	___	___	___	✓
Physician-Patient relationship:	___	___	___	✓
Competence in being able to communicate in reading, writing and speaking the English language:	___	___	___	✓
Participation in Medical Staff Affairs	___	___	✓	___

Reference Form #2
Continued

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER AT THE HOSPITAL WHERE YOU HAVE A CURRENT OR RECENT APPOINTMENT, PAGE TWO OF TWO

Name of Applicant: Joan Luster MD

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? ✓ Yes ____ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine? ____ Yes ✓ No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? ____ Yes ✓ No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.) ____ Yes ✓ No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? ____ Yes ✓ No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? ____ Yes ✓ No

Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? ____ Yes ✓ No

Do you know of a failure of the applicant to complete a residency training program(s)? ____ Yes ✓ No

Does the applicant call upon consults when needed? ✓ Yes ____ No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluating this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:
- ✓ Close personal observation
- ____ General impression
- ____ A composite of faculty/staff evaluations
- ____ Other - Specify: ____

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend Joan Luster for licensure in Vermont.
Name of Physician

Signed: Susan J. Yates MD Date: 2/13/04

Print or Type Name and Title: Susan J. Yates MD.

Reference Form #2
Return Directly to Board

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER AT THE HOSPITAL WHERE YOU HAVE A CURRENT OR RECENT APPOINTMENT, PAGE ONE OF TWO

Name of Applicant: Joan E. Lister

The physician named above has applied to the Vermont Board of Medical Practice for a license to practice medicine in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. Thank you for your cooperation.

Please complete all parts of this form. If more room is needed, please attach additional information.

Dr. Joan Lister was at North Adam Regional Hospital from 1989 to present. During that time, he/she was (List status in the institution): on active staff - (gyn) Surgical staff

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

Basic medical knowledge:	___ Poor	___ Fair	___ Average	✓ Above Average
Professional judgment:	___ Poor	___ Fair	___ Average	✓ Above Average
Sense of responsibility:	___ Poor	___ Fair	___ Average	✓ Above Average
Moral character/ ethical conduct:	___ Poor	___ Fair	___ Average	✓ Above Average
Competence and skill:	___ Poor	___ Fair	___ Average	✓ Above Average
Cooperativeness, ability to work with others:	___ Poor	___ Fair	___ Average	✓ Above Average
History & physical exam taking:	___ Poor	___ Fair	___ Average	✓ Above Average
Record keeping	___ Poor	___ Fair	___ Average	✓ Above Average
Case presentations:	___ Poor	___ Fair	___ Average	✓ Above Average
Patient management:	___ Poor	___ Fair	___ Average	✓ Above Average
Physician-Patient relationship:	___ Poor	___ Fair	___ Average	✓ Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	___ Poor	___ Fair	___ Average	✓ Above Average
Participation in Medical Staff Affairs	___ Poor	___ Fair	___ Average	✓ Above Average

Reference Form #2
Continued

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER AT THE HOSPITAL WHERE YOU HAVE A CURRENT OR RECENT APPOINTMENT, PAGE TWO OF TWO

Name of Applicant: Joan E. Lister

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? ✓ Yes ____ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice medicine? ____ Yes ✓ No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? ____ Yes ✓ No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: DWI (Driving While Intoxicated) is not minor.) ____ Yes ✓ No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? ____ Yes ✓ No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? ____ Yes ✓ No

Do you know of any confirmed quality problem (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? ____ Yes ✓ No

Do you know of a failure of the applicant to complete a residency training program(s)? ____ Yes ✓ No

Does the applicant call upon consults when needed? ✓ Yes ____ No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluating this applicant. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:
- ✓ Close personal observation
- ____ General impression
- ____ A composite of faculty/staff evaluations
- ____ Other - Specify: ____

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend Joan E Lister for licensure in Vermont.
Name of Physician

Signed: Charles E O'Neill Date: 1/13/04

Print or Type Name and Title: Charles E. O'Neill. MD

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION SUPPLEMENTAL CLEARANCE REPORT

May 24, 2004

Attn: John Howland, Jr.
Vermont Board of Med. Practice
108 Cherry Street
Burlington, VT 05402

Re: Board Action Query Dated: May 24, 2004
Your Reference Number:
FSMB Batch Number: BQ959261

The following is a report of the search results from the Board Action Data Bank as of May 24, 2004 for practitioners submitte referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of May 24, 2004

Item	Name	DOB	School	Yr/Grad
3		[redacted]	022040	2004
2	LISTER, JOAN		022040	1977