BOARD OF MEDICAL PRACTICE
P.O. BOX 70
BURLINGTON, VT 05402-0070
(802) 657-4220

LIMITED TEMPORARY LICENSE APPLICATION
STATEMENT OF SUPERVISING PHYSICIAN/ PROGRAM DIRECTOR

This section must be completed by the Supervising physician/Program Director who will be supervising your work in Vermont. This licensed physician will be responsible and liable for all negligent and wrongful acts or omissions of the limited temporary license holder. Termination of appointment as an intern, resident, fellow or medical officer of such designated hospital or institution shall operate as a revocation of such limited temporary license. This limited temporary license shall be revoked upon the death or legal incompetence of the licensed physician or upon ten days written notice of the licensed physician.

I certify that (name of applicant) Lauren MacAfee, MD is under my direct supervision and control **in a formal ACGME-approved residency program** at:

Hospital or Institution:
Fletcher Allen Health Care

Department:
111 Colchester Ave 2515MH

Address:
Burlington, VT 05401

City, State, Zip Code

For the period 6/30/2013 to 6/30/2014

I state that the above applicant is under my direct supervision and control. I further state that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of this limited temporary license holder.

Signature of Program Director/Supervising Physician

042-0009221
Program Director/Supervising Physician's Vermont License Number

Elisabeth Wegner, MD
Printed Name of Program Director/Supervising Physician

4/2/2013
Date

111 Colchester Ave. 2515MH
Address

Burlington, VT 05401
City, State, Zip Code

PLEASE MAIL COMPLETED FORM TO THE BOARD'S ADDRESS LISTED ABOVE. THANK YOU.

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
P.O Box 70
Burlington, VT 05402-0070
(802) 657-4223

LIMITED TEMPORARY PHYSICIAN LICENSE APPLICATION
STATEMENT OF PROGRAM DIRECTOR/SUPERVISING PHYSICIAN

This section must be completed by the Program Director physician who will be supervising your work while in Vermont. This licensed physician will be responsible and liable for all negligent and wrongful acts or omissions of the limited temporary license holder. Termination of appointment as an intern, resident, fellow or medical officer of such designated hospital or institution shall operate as a revocation of such limited temporary license. This limited temporary license shall be revoked upon the death or legal incompetency of the licensed physician or upon ten days written notice of the licensed physician.

I certify that _Lauren MacAfee, M.D. is under my direct supervision and control in a formal **ACGME-approved residency program at:**

Hospital:	**Fletcher Allen Health Care**
Department:	**Obstetrics & Gynecology**
Address:	**111 Colchester Avenue**
City, State, Zip Code	**Burlington, Vermont 05401**
For the period:	**07/01/2012 to 06/30/2013**

I stated that the above applicant is under my direct supervision and control. I further state that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of this limited temporary license holder.

Signature of Supervising Physician/Program Director

042-0009874
Supervising Physician/Program Director's License Number

Christine A. Murray, M.D.
Supervising Physician/Program Director's Printed Name

April 9, 2012
Date

Obstetrics & Gynecology Department
111 Colchester Avenue
Burlington, Vermont 05401

Th9omoVERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
P.O. Box 70, Burlington, VT 05402

LIMITED TEMPORARY PHYSICIAN LICENSE RENEWAL APPLICATION

I hereby apply for the renewal of my LIMITED TEMPORARY LICENSE AS A PHYSICIAN for the period from 07/01/11 to 06/30/12.

Part I

Vermont Physician's License Number: 060-0003859

1. Name: Lauren Kelly MacAfee

a. Have you ever legally changed your name? ___Yes ✓ No
If yes, enter your former name, or other name under which you were licensed in Vermont or elsewhere in the past two years;_____

b. Your name, as it should appear on your license: Lauren Kelly MacAfee

2. Date of Birth: [redacted]

[redacted]

(City) (State) (Zip)

4. Work Address:

FAHC Dept of OB/GYN
111 Colchester Avenue WP 2-272
BURLINGTON, VT 05401
maca0033@umn.edu

APR 13 2011

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

6. Home Telephone Number: [redacted]

7. Work Telephone Number: (802) 847-1400

8. E-mail address (If different than listed above): _____

Part II

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

10. Do you hold, or have you ever held, a medical license (including temporary)? in any other state? ☐ yes ☑ no
If yes, complete the section below:

State	License Number	Type of License	Date Issued	Status (Active or Inactive)

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 or any other reason?
□ 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?
□ 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

21. Do you currently or have you ever prescribed any prescription medication over the internet? This does not include prescribing you would do using electronic medical records in your practice.
□ yes ☑ no

Part III
Confidential Section (The following section is exempt from public disclosure)

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

22. To your knowledge, are you the subject of an investigation by any other licensing board under which you have not been charged as of the date of this application?
[redacted]

23. To your knowledge, are you presently the subject of criminal investigation under which you have not been charged?
[redacted]

The following definitions are provided to assist you in answering the following questions. Please explain any "**Yes**" answers on Form A.

"Ability to practice medicine" - This term includes:

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, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"Chemical substances" - This term 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.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

24. Do you have a medical condition that potentially or in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety? [redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

25. Are you currently engaged in the use of alcohol or other chemical substances that potentially or in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety? [redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

26. Are you currently engaged in the illegal use of controlled substances? [redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

IMPORTANT

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a ***confidential*** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line).

Part IV

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 try to answer the following questions as best you can. You will receive a copy of your profile 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 copies of court papers, licensing and certification authority decisions, and other documents relevant to the questions below in order to have a true and accurate description of the actions taken.

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

None reported

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

28. **Nolo Contendere/Matters Continued** [See 26 VSA § 1368(a)(2)] ☑ **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. **Please provide copies of papers fully documenting these matters.**

None reported

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

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

(Date)	(Final Disposition - Summary)

30. **Licensing or Certification Authority Matters in Other States** [See 26 VSA § 1368(a)(4)] ☑ **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. **Please provide copies of papers fully documenting these matters.**

None reported

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

31. **Restriction of Hospital Privileges** [See 26 VSA § 1368(a)(5)] ☑ **None**

A. Revocation/Involuntary Restrictions

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. **Please provide copies of papers fully documenting these matters.**

None reported

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

B. Other Restrictions ☑ **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. **Please provide copies of papers fully documenting these matters.**

None reported

(Nature of Action) (Action) (Reason for Action)

☐ In lieu ☐ In settlement

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

A. Judgments ☑ **None**

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

None reported

☐ Judgement ☐ Arbitration

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

B. Settlements ☑ **None**

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

None reported

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

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

Please provide the names of medical professional schools you attended and the dates of graduation. (We will have similar information on file with your original application; we are asking you here to provide an update for the statutory web profile.)

University of Minnesota, Minneapolis, MN
5/8/2010

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

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

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

Please provide information about any graduate medical education that you have received or will receive. (We will have similar information on file with your original application; we are asking you here to provide an update for the statutory web profile.)

UNIVERSITY OF VERMONT, VT
Obstetrics and Gynecology
2010

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

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

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

35. **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			
		☐ yes ☐ no			
		☐ yes ☐ no			

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

What month and year did you start practicing as a physician (including residency)?

~~40330~~ June, 2010

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

List all hospitals where you currently have hospital staff privileges:

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

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

Note: Answering #38 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.

None reported

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

B. Teaching

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

None reported

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

39. **Publications** [See 26 VSA § 1368(a)(13)]

Note: Answering #39 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)
(Title)	(Publication)	(Year)

40. **Activities** [See 26 VSA § 1368(a)(14)]

Note: Answering #40 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.

None reported

(Activities or Awards)

41. **Practice Setting** [See 26 VSA § 1368(a)(15)]

What is the location of your primary practice setting? □ Not applicable

Burlington, VT

Town or City State

42. **Translating Services** [See 26 VSA § 1368(a)(16)]

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: .....☐

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

A. **Medicaid participation**

Do you participate in the Medicaid program? ☑ yes ☐ no

B. **New Medicaid Patients**

Are you currently accepting new Medicaid patients? ☑ yes ☐ no

Part V

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

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: 3/17/2011

Applicant's Signature

Vermont Department of Health
Board of Medical Practice
P.O. Box 70, Burlington, VT 05402

Vermont Department of Health - Board of Medical Practice
Form A

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

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

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

_____

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

State_____ Year_____

Circumstances_____

_____

Disciplinary charges or action (Question 14) - 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_____

_____

_____

Denial of examination privileges (Question 15) - Attach documents

State_____ Year_____

Circumstances under which examination privileges denied _____

_____

_____

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

Residency Training Program(s) _____

Location of Programs _____ Year _____

Circumstances _____

_____

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

Institution involved _____

Location _____ Year _____

Circumstances _____

_____

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

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

_____

_____

_____

_____

Criminal Investigation - Proceeding (Questions 20 and 23) - Attach documents

Court _____

City and State _____

Charge _____

Description _____

_____

_____

Status _____

_____

Conviction? _____ Yes _____ No Date _____

Plea? _____ Yes _____ No Date _____

(Question 21) Internet prescribing

Please provide a general description of your practice of internet prescribing

_____

_____

Investigation by any other licensing board (Question 22) - Attach documents

Name of Licensing Board_____ Date _____

Location of Licensing Board_____

Circumstances_____

Medical condition, treatment, use of chemical or illegal substances (Questions 24-26)

Treating organization _____

Address _____Telephone _____

Type of diagnosis, condition or treatment - field of practice - use of chemical substances

_____

_____

Dates of illness of dependency _____ to _____

Dates of treatment _____ to _____

Name of Rehabilitation/Professional Assistance or Monitoring Program _____

Address _____Telephone _____

Contact person at Program _____

(Question 38) Medical Malpractice Claim

Please provide the following information regarding each instance of alleged malpractice. 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:

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:

_____

_____

_____

SPECIALTY CODES LIST

(primary care specialties in boldface)

0101 Allergy and Immunology
0102 Clinical & Laboratory Immunology

0201 Anesthesiology
0202 Critical Care Medicine
0203 Pain Management

0301 Colon & Rectal Surgery

0401 Dermatology
0402 Dermatopathology
0403 Clinical & Laboratory Dermatology
0404 Dermatological Immunology

0501 Emergency Medicine
0502 Medical Toxicology
0503 Pediatric Emergency Medicine
0504 Sports Medicine

0601 Family Practice
0602 Geriatric Medicine
0603 Sports Medicine

0701 Internal Medicine
0702 Adolescent Medicine
0703 Cardiac Electrophysiology
0704 Cardiovascular Disease
0705 Critical Care Medicine
0706 Clinical & Lab Immunology
0707 Endocrinology Diabetes & Metabolism
0708 Gastroenterology
0709 Geriatric Medicine
0710 Hematology
0711 Infectious Disease
0712 Medical Oncology
0713 Nephrology
0714 Pulmonary Disease
0715 Rheumatology
0716 Sports Medicine

0801 Medical Genetics
0802 Clinical Biochemical Genetics
0803 Clinical Biochemical/Molecular Genetics
0804 Clinical Cytogenetics
0805 Clinical Genetics (Md)
0806 Clinical Molecular Genetics

0901 Neurological Surgery
0902 Critical Care Medicine
1001 Nuclear Medicine

1101 Obstetrics & Gynecology
1102 Critical Care Medicine
1103 Gynecologic Oncology
1104 Maternal & Fetal Medicine
1105 Reproductive Endocrinology

1201 Ophthalmology

1301 Orthopaedic Surgery
1302 Hand Surgery

1401 Otolaryngology
1402 Otology/Neurotology
1403 Pediatric Otolaryngology
1501 Anatomic & Clinical Pathology
1502 Anatomic Pathology
1503 Clinical Pathology
1504 Blood Banking/Transfusion Medicine
1505 Chemical Pathology
1506 Cytopathology
1507 Dermatopathology
1508 Forensic Pathology
1509 Hematology
1510 Immunopathology
1511 Medical Microbiology
1512 Neuropathology
1513 Pediatric Pathology

1601 Pediatrics
1602 Adolescent Medicine
1603 Clinical & Laboratory Immunology
1604 Medical Toxicology
1605 Neonatal-Perinatal Medicine
1606 Pediatric Cardiology
1607 Pediatric Critical Care Medicine
1608 Pediatric Emergency Medicine
1609 Pediatric Endocrinology
1610 Pediatric Gastroenterology
1611 Pediatric Hematology-Oncology
1612 Pediatric Infectious Disease
1613 Pediatric Nephrology
1614 Pediatric Pulmonology
1615 Pediatric Rheumatology
1616 Pediatric Sports Medicine
1617 Children with Special Health Needs

1701 Physical Medicine & Rehabilitation

1801 Plastic Surgery
1802 Hand Surgery

1901 Preventive Medicine
1902 Aerospace Medicine
1903 Occupational Medicine
1904 Public Health & General Preventive
1905 Medical Toxicology
1906 Underseas Medicine

Psychiatry & Neurology
(Board Name - Not A Specialty)
2001 Psychiatry
2002 Neurology
2003 Neurology With Special Qualifications In Child Neurology
2004 Addiction Psychiatry
2005 Child & Adolescent Psychiatry
2006 Forensic Psychiatry
2007 Geriatric Psychiatry
2008 Clinical Neurophysiology

2101 Radiology
2102 Diagnostic Radiology
2103 Radiation Oncology
2104 Radiological Physics
2105 Nuclear Radiology
2106 Pediatric Radiology
2107 Vascular & Interventional Radiology

2201 Surgery
2202 Surgery Of The Hand
2203 Pediatric Surgery
2204 Surgical Critical Care
2205 General Vascular Surgery
2301 Thoracic Surgery

2401 Urology

4001 Abdominal Surgery
4002 Acupuncture
4003 Addiction Medicine
4004 Adult Reconstructive Orthopedics
4005 Allergy

4006 Cardiovascular Surgery
4007 Clinical Pharmacology
4008 Diabetes

4009 Facial Plastic Surgery

4010 General Practice

4011 Gynecology
4012 Head & Neck Surgery
4013 Hepatology
4014 Homeopathic Medicine
4015 Immunology

4016 Legal Medicine
4017 Musculoskeletal Oncology
4018 Neuroradiology
4019 Nutrition
4020 Obstetrics

4021 Oral & Maxillofacial Surgery
4022 Orthopedic Surgery Of The Spine
4023 Orthopedic Trauma
4024 Pain Medicine
4025 Pediatric Allergy

4026 Pediatric Ophthalmology
4027 Pediatric Orthopedics
4028 Pediatric Surgery (Neurology)
4029 Pediatric Urology
4030 Psychoanalysis

4031 Radioisotopic Pathology
4032 Sports Medicine (Orthopedic Surgery)
4033 Traumatic Surgery
4034 Sleep Medicine

9001 Rotating Internship (Residency)
9999 Other - Please Specify

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05402-0070
medicalboard@vdh.state.vt.us
802-657-4220 or 800-745-7371

LIMITED TEMPORARY PHYSICIAN LICENSE RENEWAL APPLICATION
STATEMENT OF SUPERVISING PHYSICIAN/PROGRAM DIRECTOR

This section must be completed by the physician who will be supervising your work while in Vermont. This licensed physician will be responsible and liable for all negligent and wrongful acts or omissions of the limited temporary license holder. Termination of appointment as an intern, resident, fellow or medical officer of such designated hospital or institution shall operate as a revocation of such limited temporary license. Such limited temporary license shall be revoked upon the death or legal incompetency of the licensed physician or upon ten days written notice of the enclosed physician.

I certify that Lauren MacAfee (name of applicant) is engaged as an intern, resident, fellow or medical officer at:

Hospital: Fletcher Allen Health Care

Department: Obstetrics, Gynecology and Reproductive Sciences

Address: SM4215 111 Colchester Avenue

City, State, Zip Code Burlington, Vermont 05472

For the period July 1, 2011 to June 30, 2012.

I state that the above applicant is under my direct supervision and control. I further state that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of this limited temporary license holder.

Signature of Supervising Physician/Program Director

042-0009874
Supervising Physician/Program Director's License Number

Christine A. Murray, M.D.
Supervising Physician/Program Director's Printed Name

March 17, 2011
Date

251SM4 111 Colchester Ave.
Address

Burlington, Vermont 05472
City, State, Zip Code

Please mail completed form to the Board's address listed above. Thank you.

State of Vermont

Department of Health

Board of Medical Practice

Statement of Good Standing

Regarding Any Unpaid Judgment Issued by the Judicial Bureau or District Court for Fines or Penalties for a Violation or Criminal Offense

I hereby state that I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

I understand that a license may not be issued or renewed without such a statement.

I further understand that, for the purposes of this section, a person is in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense if:

(1) 60 days or fewer have elapsed since the date a judgment was issued; or

(2) the person is in compliance with a repayment plan approved by the judiciary.

Signature: _____

Date: 3/17/2011

VERMONT'S PRESCRIPTION CONFIDENTIALITY LAW
Prescriber Data-Sharing Program

CONSENT FORM

Under Vermont's Act 80, a law passed in 2007, pharmaceutical companies may not use information that identifies prescribers in prescription drug records for marketing or promoting prescription drugs unless the prescriber consents. The text of the law, which took effect July 1, 2009, is found at 18 V.S.A. § 4631. The Vermont Attorney General has links to the statute and further information about the implementation of this law on the website. Go to http://www.atg.state.vt.us/ and follow the link for Prescribed Products and then look for information on Prescription Confidentiality.

If you wish, you may permit your identifying information in drug prescription records to be used for marketing and promoting of prescription drugs. The only way to grant permission is by giving your consent in the manner described below. If you do not consent, your identifying information from prescription drug records cannot be used for marketing or promoting prescription drugs.

The list of everyone who has a current consent on file with their licensing board, as well as consent and revocation forms are available online at: http://healthvermont.gov/hc/med_board/bmp.aspx. You may check this site at any time to confirm your status. If you consent, your consent is effective until you revoke your consent. **If you wish to make a change, you may download consent and revocation forms at the web address above. If you do not have web access, you may contact your licensing board for assistance.**

How to consent: If you want to consent to the use of your information for marketing and promoting prescription drugs, sign your name, complete the form, and return it as part of your license application or license renewal. If you consent, your name will be included on the list of Vermont prescribers who have consented, and your information may be used for marketing and promoting prescription drugs. You may also complete this form at any time and mail it to your licensing board.

If you do not consent: If you do not wish your identifying information in prescription drug records to be used for marketing or promoting prescription drugs, you need do nothing.

If you choose not to consent, please leave this form blank.

* *

To consent, sign, date, and fill out the form below. Return the completed form with your license application or license renewal or mail the form to **Board of Medical Practice, PO Box 70, Burlington, VT 05402-0070.**

I consent:

_____ _____
Signature Date

_____
Name (printed or typed)

_____ _____
License type (profession) Vermont License Number

_____
Mailing Address

_____
City, State, Zip

VERMONT'S PRESCRIPTION CONFIDENTIALITY LAW
Prescriber Data-Sharing Program

REVOCATION OF CONSENT FORM

If at any time a prescriber wishes to revoke his or her consent to use of prescriber identifiable drug information, the revocation must occur using this form.

I _____ **(print name)** hereby **revoke** my consent to the use of regulated records which include prescription information containing my prescriber-identifiable data for the purpose of marketing or promoting a prescription drug.

_____ _____
Signature Date

_____
Name (printed or typed)

_____ _____
License type (profession) Vermont License Number

_____
Mailing Address

_____
City, State, Zip

Please mail your completed form to:

Board of Medical Practice
Vermont Department of Health
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 shall 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 and payable and all returns have been filed, 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 _____ Date 3/17/2011

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
P.O. Box 70, Burlington, VT 05402

LIMITED TEMPORARY PHYSICIAN LICENSE APPLICATION

I hereby make application for a Limited Temporary License to practice medicine and surgery as an intern resident, fellow or medical officer in the State of Vermont at the Fletcher Allen Health Care **Hospital or Institution, Department of** Obstetrics & Gynecology **, under the supervision of** Christine Murray **, MD and submit the following information.**

Part I

1. Name: MacAfee (Last) Lauren (First) Kelly (Middle) (Extension) 2010

a. Have you ever legally changed your name? ___Yes ✓ No
If yes, enter your former name, or other name under which you were licensed in Vermont or elsewhere in the past two years;_____

b. Your name, as it should appear on your license: Lauren Kelly MacAfee

2. Date of Birth: [redacted]

[redacted]

4. Work Address:
111 Colchester Ave Smith 415 Mailstop 251SM4 (Street)

Burlington (City) VT (State) 05401 (Zip)

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

6. Home Telephone Number: [redacted]

7. Work Telephone Number: (802) 847-4736

8. E-mail address: [redacted]

Part II

9. Are you currently participating in residency or fellowship training? ☐ yes ☑ no

10. Do you hold, or have you ever held, a medical license (including temporary) in any other state? ☐ yes ☑ no
If yes, complete the section below:

State	License Number	Type of License	Date Issued	Status (Active or Inactive)

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 or any other reason?
☐ 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?
☐ 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

21. Do you currently or have you ever prescribed any prescription medication over the internet?
☐ yes ☑ no

Part III
Confidential Section (The following section is exempt from public disclosure)

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

22. To your knowledge, are you the subject of an investigation by any other licensing board under which you have not been charged as of the date of this application?

23. To your knowledge, are you presently the subject of criminal investigation under which you have not been charged?

The following definitions are provided to assist you in answering the following questions. Please explain any "**Yes**" answers on Form A.

"Ability to practice medicine" - This term includes:

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, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a licensee.

"Chemical substances" - This term 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.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

24. Do you have a medical condition that potentially or in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

25. Are you currently engaged in the use of alcohol or other chemical substances that potentially or in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

26. Are you currently [redacted] engaged in the illegal use of controlled substances?

In explaining a "Yes" answer on Form A, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

IMPORTANT

Since 1999, part of each license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a **confidential** program for the identification, treatment and rehabilitation of physicians affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line).

Part IV

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 try to answer the following questions as best you can. You will receive a copy of your profile 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 copies of court papers, licensing and certification authority decisions, and other documents relevant to the questions below in order to have a true and accurate description of the actions taken.

27. **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. 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.**

☑ Not applicable

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

28. **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.**

☑ Not applicable

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

29. **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.
☑ Not applicable

(Date) (Final Disposition - Summary)

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

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. **Please provide copies of papers fully documenting these matters.**
☑ Not applicable

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

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

31. **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 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.**
☑ Not applicable

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

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

B. **Other Restrictions**

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. **Please provide copies of papers fully documenting these matters.**
☑ Not applicable

(Date) (Hospital) (State)

(Nature of Action) (Action)

(Reason for Action) ☐ In lieu ☐ In settlement

32. **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 in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**
☑ Not applicable

☐ Judgement ☐ Arbitration

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

☐ Judgement ☐ Arbitration

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

B. **Settlements**

Please provide a description of all settlements of medical malpractice claims against you in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**
☑ Not applicable

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

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

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

Please provide the names of medical professional schools you attended and the dates of graduation. (We will have similar information on file with your original application; we are asking you here to provide an update for the statutory web profile.) Please attach a copy of diploma.

(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation/Anticipated Year of Graduation)
University of Minnesota Medical School	MD	Minneapolis	MN	5/2010

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

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

Please provide information about any graduate medical education that you have received or will receive. (We will have similar information on file with your original application; we are asking you here to provide an update for the statutory web profile.)

(School/Institution)	(Specialty)	(City)	(State)	(Year of Graduation)	(Anticipated Training)
Fletcher Allen Healthcare/ University of Vermont	OB/Gyn	Burlington	VT	2014	Residency

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

35. **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	Obstetrics & Gynecology	☐ yes ☑ no			
		☐ yes ☐ no			
		☐ yes ☐ no			

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

What month and year did you start practicing as a physician (including residency)?
July, 2010

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

List all hospitals where you currently have hospital staff privileges. ☑ Not applicable

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

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

38. **Appointments/Teaching** [See 26 VSA § 1368(a)(12)] ☑ Not applicable

Note: Answering #38 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)

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

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)

39. **Publications** [See 26 VSA § 1368(a)(13)] ☑ Not applicable

Note: Answering #39 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. ☑ Not applicable

(Title) (Publication) (Year)

(Title) (Publication) (Year)

40. **Activities** [See 26 VSA § 1368(a)(14)] ☑ Not applicable

Note: Answering #40 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)

41. **Practice Setting** [See 26 VSA § 1368(a)(15)]

What is the location of your primary practice setting? ☐ Not applicable

Burlington VT

Town or City State

42. **Translating Services** [See 26 VSA § 1368(a)(16)]

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:

Yes, available on request

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

A. **Medicaid participation**

Do you participate in the Medicaid program? ☑ yes ☐ no

B. **New Medicaid Patients**

Are you currently accepting new Medicaid patients? ☑ yes ☐ no

Part V

Photograph
PLEASE PROVIDE A PHOTOGRAPH:
Attach a recent photograph (head and shoulders). Proofs are not acceptable.
Please sign the front of the photograph.
Do not use staples.

PHOTOGRAPH

Part VI

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

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: 4/5/10

Applicant's Signature

Vermont Department of Health
Board of Medical Practice
P.O. Box 70, Burlington, VT 05402

Vermont Department of Health
Board of Medical Practice
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
medicalboard@vdh.state.vt.us
802-657-4220 or 800-745-7371

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:

I, Lauren Kelly MacAfee HEREBY AUTHORIZE YOU to furnish to
(Name of Applicant)

the 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 professional experience and qualifications, my licensing history, my practice, 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.

Signature: [signature]

Date: 4/5/10

Print or Type Name: Lauren Kelly MacAfee

Address: [redacted]

City, State,

Telephone

Subscribed and sworn to before me, this 5th day of April 2010

Notary Public

A CONFORMED COPY, ATTEST Teresa M. Kes
Notary Public

TERESA M KES
NOTARY PUBLIC – MINNESOTA
My Commission Expires Jan. 31, 2015

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

State of Vermont

Department of Health

Board of Medical Practice

Statement of Good Standing

Regarding Any Unpaid Judgment Issued by the Judicial Bureau or District Court for Fines or Penalties for a Violation or Criminal Offense

I hereby state that I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

I understand that a license may not be issued or renewed without such a statement.

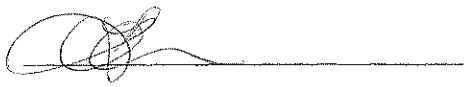
I further understand that, for the purposes of this section, a person is in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense if:

(1) 60 days or fewer have elapsed since the date a judgment was issued; or

(2) the person is in compliance with a repayment plan approved by the judiciary.

4/5/10

Date



Signature

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 shall 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 and payable and all returns have been filed, 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 _____ Date 4/6/10

BOARD OF MEDICAL PRACTICE

P.O. BOX 70
BURLINGTON, VT 05402-0070
(802) 657-4220

LIMITED TEMPORARY LICENSE APPLICATION
STATEMENT OF PROGRAM DIRECTOR/SUPERVISING PHYSICIAN

This section must be completed by the Program Director/physician who will be supervising your work in Vermont. This licensed physician will be responsible and liable for all negligent and wrongful acts or omissions of the limited temporary license holder. Termination of appointment as an intern, resident, fellow or medical officer of such designated hospital or institution shall operate as a revocation of such limited temporary license. This limited temporary license shall be revoked upon the death or legal incompetence of the licensed physician or upon ten days written notice of the licensed physician.

I certify that (name of applicant) Lauren MacAfee is under my direct supervision and control **in a formal ACGME-approved residency program** at:

Hospital or Institution:
FAHC - UVM

Department:
OB/Gyn

Address:
111 Colchester ave. 251 SMU

City, State, Zip Code
Burlington, VT 05401

For the period July 1, 2010 to June 30, 2011

I state that the above applicant is under my direct supervision and control. I further state that I shall be legally responsible and liable for all negligent or wrongful acts or omissions of this limited temporary license holder.

Signature of Program Director/Supervising Physician

042-009 874
Program Director/Supervising Physician's Vermont License Number

Christine A. Murray
Printed Name of Program Director/Supervising Physician

April 9, 2010
Date

111 Colchester ave. 251 SMU
Address

Burlington, VT 05401
City, State, Zip Code

PLEASE MAIL COMPLETED FORM TO THE BOARD'S ADDRESS LISTED ABOVE. THANK YOU.

Vermont Department of Health – Board of Medical Practice

PRESCRIBER DATA-SHARING PROGRAM CONSENT FORM

Under Vermont's Act 80, a law passed in 2007, a prescriber may give consent so that his or her identifiable data in prescription drug records may be used for marketing or promoting prescription drugs. If a prescriber chooses not to consent, the use of prescriber's identifiable data in prescription drug records is restricted as provided for in the law. The text of the law is found at 18 V.S.A. § 4631. The Board of Medical Practice has provided a fact sheet with additional information about this law and its implementation.

If you choose to consent to the use of your identifiable data in prescription drug records for marketing or promoting prescription drugs, please check the "I consent" box and sign next to it. Your consent is effective for this licensing or certification period. If you choose not to consent, please leave this section blank. If you complete this form, please return it to the Board of Medical Practice with your completed license or certification application or renewal form.

You may revoke your consent at any time by signing the Revocation of Consent form and sending it to the Board of Medical Practice.

__ I consent _____
Signature

4/5/10
Date

Lauren K. MacAfee
Print Name

_____
Vermont License or
Certification Number

Lauren K. MacAfee

[redacted]

EDUCATION

Doctor of Medicine – Expected May, 2010
University of Minnesota Medical School – Minneapolis, Minnesota

Bachelor of Science, Magna Cum Laude, *Biochemistry* – May, 2005
Mary Washington College – Fredericksburg, Virginia

HONORS AND AWARDS

Neil L. and Sarah Gault International Study Award Recipient – 2009
Chancellor Volunteer Fire and Rescue EMS Rookie of the Year – 2004

PUBLICATIONS AND POSTERS

L MacAfee, D Wiesner, D Boulware. Cost Analysis of Lyme Disease Screening in a High Risk Population.. Manuscript to be submitted, December, 2009.

J Bahr, A Lapine, **L MacAfee**, J Ho. The Utility of Point-of-Care Carbon Monoximetry in Fireground EMS Rehabilitation Operations. Abstract submitted to the Society for Academic Emergency Medicine Annual Meeting, 2009.

L MacAfee, L Giancarlo. DNA Topology Studies Using Atomic Force Microscopy. 56th Southeastern Regional Meeting of the American Chemical Society, Research Triangle Park, North Carolina, November, 2004. [Poster Presentation]

EXPERIENCE

CLINICAL

Human Anatomy Teaching Assistant – University of Minnesota Medical School, Minneapolis, Minnesota – August through October, 2008

Health Officer and Director – Northern Star Council, Boy Scouts of America, Saint Paul, Minnesota – June, 2005 through March, 2008

Medical Internship – Korle Bu Teaching Hospital, Accra, Ghana – Summer, 2007

Senior Member, EMT-Basic – Chancellor Volunteer Fire and Rescue, Fredericksburg, Virginia – Spring, 2004 through Summer, 2005

RESEARCH

Research Associate – Hennepin County Medical Center Emergency Department, Minneapolis, Minnesota – Fall, 2006 through Spring, 2007

Clinical Studies Coordinator – Medtronic Contractor, Minneapolis, Minnesota – Fall, 2005 through Spring, 2006

EXTRACURRICULAR

LEADERSHIP

University of Minnesota Wilderness Health Society – Vice-President, 2007-2008
University of Minnesota Emergency Medicine Interest Group – Treasurer, 2007-2008
University of Minnesota Women in Medicine – Officer, 2007-2008
University of Minnesota American Medical Student Association – Officer, 2007-2008

VOLUNTEER

Girl Scouts of Greater Iowa – Volunteer, 2000 through current
Northern Star Council, Boy Scouts of America – Volunteer, 2005 through current
Sierra Club Inner City Outings – Volunteer, 2008 through current

HOBBIES

Backpacking, sailing, canoeing, snowshoeing, and international travel

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
P.O. BOX 70
BURLINGTON, VT 05402-0070
(802) 657-4220

APPLICATION FOR LIMITED TEMPORARY LICENSE

CERTIFICATE OF MEDICAL EDUCATION

MAY 17 2010

To be completed by an *officer of your school of medicine*

I hereby certify that Lauren K. MacAfee (Name) was admitted to the

University of Minnesota School of Medicine in

Minneapolis, MN (City/State) on 08/07/2006

and

completed all requirements for graduation on 05/08 May 8, 2010 (Date)

A Doctor of Medicine (Specify Certificate/Diploma/Degree) was granted/will be granted on

May 8, 2010 (Date)

Date: May 6, 2010

Signed: [signature] [Affix Seal]

Printed Name: Kathleen V. Watson, M.D.

Title Associate Dean for Students and Student Learning