

Application - Physician

Name	Jamie Michele
Credential	Physician

Fee Details

Application Fee-Initial	\$650.00
	\$650.00

Introduction

To Our Physician Applicants:

The Board of Medical Practice is pleased that you have chosen to apply for a Vermont medical license. Please take a moment to read all instructions before completing the application. We also recommend that you review the Board Rules to ensure you meet the eligibility requirements. They are available at: .

The Board and its staff work hard to make the process go as smoothly and as quickly as possible, consistent with the weighty responsibility to ensure that applicants meet all requirements of the law and regulations. You can help speed your application through the process by: providing complete and accurate information; submitting the correct fee as required; promptly arranging for all required direct-source verifications; and being mindful of the need for supporting documents to be legible, including reference forms. We recommend that you check your work. Even innocent omissions and errors can lead to delays. On a more serious note, intentional omissions, inaccuracies, or falsification of documents could lead to denial of an application, or disciplinary action if discovered after licensure.

Instructions for completing the Application for Licensure to Practice Medicine in Vermont

Please read these instructions carefully. Note that the time it can take to arrange for direct submission of documentation to the Board is the most frequent cause for delay in the licensing process. The Board also wants you to understand that your application will be subject to disclosure as a public record, with the exception of certain personal information. Those parts of the application that are firmly established as confidential, and not subject to public disclosure, are noted as such. If you have questions about the inclusion of private information, ask before you submit your application.

Application Fee: \$650.00 The fee is not refundable, regardless of whether after having paid you are denied licensure, fail to fully complete your application, or withdraw your application.

- To complete this application you must download the forms located [here](#) and send them to the Board.

NOTE – Once again, we ask that you read the following instructions regarding documentation carefully, even if you are using the Federal Credentials Verification Service (FCVS). Some of the following are NOT collected and forwarded as part of the FCVS process. The Board will not take action on an incomplete application.

Examination Transcript – Request that a transcript of your exam scores be sent directly to the Vermont Board of Medical Practice from the appropriate examining entity. If you are using FCVS, they will obtain exam score transcripts based on the information you provide in the FCVS application. For applicants who have taken any component of the NBME in conjunction with another exam (USMLE or FLEX), you must request the transcripts from each entity.

- USMLE/FLEX/SPEX – Request transcripts online at www.fsmb.org or call (817) 868-4000.
- NBME – Download the request form at www.nbme.org/Cert-tran/certification.html or call (215) 590-9500.
- State exam – Contact the licensing board for the state in which you took the exam. FSMB maintains a state board directory at: http://www.fsmb.org/directory_smb.html .
- LMCC – Information about requesting documents from the Medical Council of Canada is online at http://www.mcc.ca/en/mcc_docs/index.shtml or you may call (613) 521-6012.

Educational Commission for Foreign Medical Graduates (ECFMG) – If applicable to you, you must submit a request to ECFMG to send a Confirmation Report of ECFMG Certification directly to the Vermont Board of Medical Practice. (If you are using FCVS, you must complete the ECFMG release form that is provided by FCVS and submit it to FCVS.)

- Address for ECFMG: <http://www.ecfm.org/cvs/index.html> or call (215) 386-5900

American Medical Association Profile – You must request an AMA profile, regardless of whether or not you are an AMA member. To submit your profile request, you must visit the AMA website at: <https://profiles.ama-assn.org/amaprofiles>. If you have questions, call the AMA at (800) 665-2882. Ensure that you request the profile to be sent directly to the Board from the AMA.

National Practitioner Data Bank Self-Query - The NPDB is a federally-mandated and operated data bank of licensing board disciplinary actions, certain peer review actions, and malpractice payments. **You must submit a request for the NPDB self-query report using their online process. NPDB will offer you the option of an electronic or paper copy of the report. We will accept either, but you must forward the self-query report to the Vermont Board of Medical Practice as part of your application for a Vermont medical license.** To apply for the self-query report you must follow this link: <https://www.npdb-hipdb.hrsa.gov> **Carefully follow the instructions. Be sure that when you select the type of query, you select the “individual” option.** NPDB will send the self-query only to the individual. When you receive it, **you must forward the original, unaltered document** to the Vermont Board of Medical Practice.

Certified Birth Certificate – You must submit your **certified** birth certificate. Note that only the issuing authority can provide a certified birth certificate; a notarized copy is not a certified birth certificate. The certified birth certificate will not be returned to you. Also note that passports are not accepted as a substitute for a certified birth certificate (regardless of what you might see on the Uniform Application checklist). If you are using FCVS and have notified them that you are applying for a Vermont license, your birth certificate should be collected by FCVS, but they do not always remember to do so. If you are using FCVS and they do not ask you to provide your certified birth certificate, be sure to do so in order to avoid risk of delay.

American Specialty Board Certificate – If you are Specialty Board Certified, you must submit a copy of the certificate to the Vermont Board of Medical Practice with your application.

Curriculum vitae – You must submit a copy of your c.v. or résumé.

Malpractice Claim Documentation – If you have reportable malpractice history, you must download Form A, carefully complete a form for each case, and submit it along with the required documentation. For your application, reportable malpractice includes:

- Pending claims that have not been resolved.
- Cases that resulted in a payment by you or on your behalf, whether as a settlement, arbitration award, or court verdict.
- Note that you need not report cases that were resolved in your favor with no payment by you or on your behalf. This includes cases that were withdrawn without payment, dismissed without payment, or resolved by a verdict in your favor.

Reference Forms – All required copies of Addendum 4A, the reference form, must be submitted directly to the Vermont Board of Medical Practice by the person providing the reference. Give a copy of the form to each person you list as a reference and ask them to submit it directly to the Board. Note that the requirement in law is for a total of three references from the “chief of service and two other active physician (MD) staff members at the hospital where the person was last affiliated.” 26 V.S.A. § 1391(a). If you have not been affiliated with a hospital in recent years, or are otherwise unable to provide references from physicians in the three positions indicated above, contact us to get more information about appropriate references.

Other State, Territory, or Province License Verifications – If you have ever been licensed or certified to practice medicine (at any level, whether a permanent, temporary, or training license) in another United States state or territory, or Canadian province or territory, then you must arrange for those licensing authorities to send verification directly to the Vermont Board of Medical Practice. More detailed directions are found at Question 25.

Affidavit, Authorization for Release of Information, and Photograph – You must print, complete, and submit this form. The link to the form and directions are found after Question 27.

Additional Documentation – Note that some applicants may be required to submit additional documentation, as indicated with the directions for specific questions. For instance, if you have changed your name, you must submit legal documentation (marriage certificate, divorce decree, or court order) of the change (Questions 1-4, 7).

Uniform Application for Physician Licensure (UA) Vermont was one of the first states to incorporate the Uniform Application for Physician Licensure (UA) into its Medical Licensing Application. We hope that physicians who apply to multiple states find the use of a common set of core questions to be a convenience. If you have previously used the UA, you may find it helpful to consult your prior answers, but please remember that you are still responsible for your answers being complete, accurate, and current even if you rely on UA answers that you prepared in the past.

Federation Credentials Verification Service (FCVS) FCVS is a service offered by the Federation of State Medical Boards. Its function is to create a permanent, verified repository of documents physicians need for licensing and credentialing. The Board accepts, but does not require, the use of FCVS for primary source credentials verification. Completion of the FCVS process can take longer than the Vermont licensing process, so plan accordingly and focus first on FCVS if you intend to use that service to submit documents in support of your Vermont application. FCVS is accepted by most states and territories. It covers: identity; medical education; postgraduate training; examination history; Board action/discipline history; ECFMG Certification (if applicable); and, ABMS Board Certification. **Note: use of FCVS does not eliminate the need to complete this application for a Vermont medical license. FCVS only facilitates submission of verified documentation in support of the application.**

There is a fee for the initial FCVS process, then a smaller charge for having your verified file forwarded to additional licensing or credentialing authorities. Information about FCVS is found online at: http://www.fsmb.org/fcvs_overview.html. You can also call 888-ASK-FCVS (or, outside the U.S. 817-868-5000) for additional information.

Name & Address

Name:

Indicate your full legal name (use no initials). If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Last Name:

Michele

2. First Name:

Jamie

3. Middle Name:

Michele

4. Suffix:

5. M.D. or D.O.?

M.D.

6. All other names used:

Previous Name	From Month	From Year	To Month	To Year	Reason for Change
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7. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

Address/Phone:

Please complete all sections. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website; therefore, you should consider what your preferred address is for these purposes.

8. Enter your MAILING ADDRESS information:

Attention [REDACTED]

Address 1 [REDACTED]

Address 2

City [REDACTED]

State [REDACTED]

Zip [REDACTED]

Country United States

Email Address licensing-jamie.phifer@98point6.com

Telephone Number [REDACTED]

Alternate Phone
Number9. Enter your PUBLIC ACCESS address information:

Attention 98point6

Street 701 5th Ave STE 2300

City Seattle

State WA

Zip 98104

Country United States

Identification

If you have not provided one to FCVS you must submit a certified birth certificate. Notarized copies and passports are not accepted.

10. Date of Birth:

[REDACTED]

11. Birth City:

[REDACTED]

12. Birth State/Province:

[REDACTED]

13. Birth Country:

United States

14. Gender:

Female

15. Social Security Number:

[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.

16. NPI Number:

[REDACTED]

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to www.cms.gov.

17. Are you a U.S. Citizen?

Yes

Medical School

To ensure the eligibility of your school, please refer to the California Medical Board approved school list (available [here](#).)

18. Medical Schools:

List all medical schools you have attended, even those from which you did not graduate, in chronological order. If you are not using FCVS, you must complete the "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must forward all documentation directly to this Board.

School	Graduation Date
School Name: University of Florida State: Florida Country: United States School Type: Medical School Degree: MD	05/14/2011

19. Fifth Pathway (if applicable):

If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

School	Graduation Date
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Postgraduate Training

Postgraduate Training: List all postgraduate programs you have attended, even those you did not complete. If you are not using FCVS, you must complete the "Postgraduate Training Verification" form and send it to all postgraduate training programs you have attended. You must upload a copy of your certificate of program completion to this Board. Additionally, the postgraduate program must provide this Board with the Program Director's recommendation letter. The postgraduate program must forward all documentation directly to this Board.

20. Postgraduate Training (do not use abbreviations):

Site Name	End Date	Specialty
Swedish Cherry Hill Family Medicine Residency	06/21/2014	Family Practice

Examination History

Examination History:

If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

21. List each licensure examination, U.S. or international, you have taken.

Examination	State	Most Recent Date Taken	Pass?	Score	Number of Attempts
USMLE Step 1	Florida	06/30/2009	Yes		1
USMLE Step 2, CK	Florida	07/28/2010	Yes		1
USMLE Step 2, CS	Georgia	09/03/2010	Yes		1
USMLE Step 3	Washington	05/07/2013	Yes		1

ECFMG

ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG website at www.ecfm.org.

ECFMG (if applicable):

22. Certificate Number:

23. Issue Date:

24. Valid Through Date:

State/Province Professional Licensure

State/Province Professional Licensure whether temporary or permanent: List all states and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license or certification. You must also complete the "Licensure Verification" for (Form #1) and forward it to all states or provinces in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

25. State Licensure

State	Profession	License Number	Issue Date	Expiration Date	Status
Maryland	MD	D87604	05/30/2019	09/30/2019	Active
New Jersey	MD	25MA10601400	05/21/2019	06/30/2021	Active
Kansas	MD	04-40305	08/11/2017	07/31/2018	Expired
Florida	MD	ME125540	09/08/2015	01/31/2020	Active
Washington	MD	MD60359609	07/05/2013	08/25/2020	Active
Massachusetts	MD	281320	09/26/2019	08/25/2020	Active
Illinois	MD	036150427	08/07/2019	07/31/2020	Active

Chronology of Activities

Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation and continuing to the present date, using MONTH and YEAR where asked for dates. For periods in excess of 30 consecutive days when you were not working, you must state the nature of your activity such as "vacation" or "seeking employment." For such periods, use your residence address at the time. If you worked for a physician-staffing group, or as a *locum tenens* provider, you must treat each facility where you worked as a different activity. For each period you report, be sure to indicate the percentage of duties that were clinical and the percentage that were administrative, or indicate "N/A" for periods when you were not working. The résumé or c.v. submitted with your application is not a substitute for completion of this Question.

26. Chronology of Activities

Practice/Employment Name	Street Address	City	State	Zip Code	Position and Department	Experience Type	Start Date	End Date	% Clinical / % Administrative
Swedish Cherry Hill Family Medicine Residency	550 16th Ave #400	Seattle	Washington	98122	Resident Physician; Family Medicine	Residency	06/21/2011	06/24/2014	100% clinical
					N/A	Other	05/15/2011	06/20/2011	N/A

Vacation/Travel to Residency Site									
Swedish Medical Group	600 University Street #1200	Seattle	Washington	98101	Primary and Urgent Care Physician; Float Pool	Employment	08/26/2014		100% clinical
98point6	701 5th Ave STE 2300	Seattle	Washington	98104	Telemedicine Physician	Employment	09/13/2019		80% Clinical 20% Administrative
Seeking Employment					Seeking Employment	Other	06/25/2014	08/25/2014	

Medical Malpractice Claims Information

27.

Malpractice Liability Claims Information

For this question, and this question only, your answer should take into consideration those claims that have been resolved entirely in your favor, as well as claims that have not yet been resolved and those that resulted in a verdict, judgment, settlement, or award against you. As noted in the directions at the beginning of this application, you need not submit the form or documentation for cases that have been resolved in your favor.

Have you ever been involved in a Malpractice Liability Claim?

No

Affidavit & Authorization for Release of Information

Affidavit and Authorization for Release of Information:

To complete this application you must download the [Affidavit and Authorization for Release of Information](#) form and attach a recent (less than 6 months old) passport quality, color photograph of yourself. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to the Board.

Addendum 1

28. Were you in active clinical practice in the past 12 months?

Yes

29. Years of Practice

What year did you start practicing as a medical professional?

2011

30. Do you have, or have you ever had, a Drug Enforcement Agency (DEA) Registration Number that allows you to prescribe controlled substances?

Yes

31. Enter each active DEA Registration Number:

FP3498842

32. Premedical Education

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

School	Graduation Date
School Name: State: Florida Country: United States School Type: Post Secondary Degree: Bachelors	05/05/2007

33. Specialty Board Certifications

Specialty	Certification Board	Certification Date	Specialty Expiration Date
Family Practice	American Board of Family Medicine	06/25/2014	06/25/2024

34. Practice

Do you have hospital privileges?

No

35. Has your driver's license ever been suspended or conditioned as a result of either (a) a refusal to provide a sample of breath or blood upon request by a law enforcement office; or (b) a civil (non-criminal) process for driving under the influence of drugs or alcohol? If you answer yes, please email an explanation and documents regarding the action.

No

36. List all hospitals where you have, or previously have had, staff privileges.

Facility Name	State	Start Date	End Date
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Statutory Profile Questions

In accordance with Vermont law, the Board of Medical Practice collects certain information from licensed or certified health care professionals and maintains it in a data repository that is made available to the public. 26 V.S.A. § 1368. The publicly-available data base is commonly referred to as the online profile. When licenses are issued to applicants, instructions are provided as to how to review and update the information provided for the online profile. Answering these questions is mandatory, except for certain optional questions. Those that are optional are clearly identified. Information collected for the statutory profiles may be considered by the Board in its review of the license application. Statutory profile information is displayed to the public for only ten years, but the questions are not time-limited and you must respond regarding your full history.

Applicants with other events or actions that must be reported (e.g., a criminal conviction) must provide documentation of each event. It is very important for the Board to receive copies of court papers, licensing authority decisions, or similar documentation, as noted below. The Board will not act on an application that lacks required documentation. **If any reportable event involves alcohol or drugs in any way, you must contact the Vermont Practitioner Health Program to arrange for an evaluation. The Board will not act on an application that is missing a required evaluation.** You may contact VPHP at (802) 223-0400. Information about VPHP is online at: <http://www.vtmd.org/health-professional-wellness-and-recovery-programs>.

37. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] Have you been convicted of any crime? This includes both misdemeanors and felonies; it includes crimes such as driving under the influence (DUI), but not non-criminal traffic offenses such as speeding or parking tickets. For purposes of this question, "convicted" means that you pleaded guilty or were adjudged guilty by a court of competent jurisdiction.

No

38. **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 adjudged guilty by a court of competent jurisdiction. **Please provide copies of papers fully documenting the convictions.**

Date of Conviction	Court of Conviction	City	State	Description
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39. **Nolo Contendere/Matters** [See 26 VSA § 1368(a)(2)] Have you ever had a criminal involvement that resulted in a case resolved by a plea of "nolo contendere," or where after finding facts that would establish guilt the matter was continued by the court in lieu of a conviction?

No

40. **Nolo Contendere/Matters Continued** [See 26 VSA § 1368(a)(2)] Provide information regarding each criminal involvement resolved by a plea of "nolo contendere," or where after finding facts that would establish guilt the matter was continued by the court in lieu of a conviction.

Date of Charges	Court	City	State	Description of Charges
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41. **Vermont Board of Medical Practice Matters** [See 26 VSA § 1368(a)(3)] Have you ever been served charges by, or been the subject of an order by the Vermont Board of Medical Practice or other Vermont professional licensing authority? (This includes stipulations, consent orders, or other voluntary resolutions that you accepted after being notified of an investigation, even if no charges were served.)

No

42. **Vermont Board of Medical Practice Matters continued** [See 26 VSA § 1368(a)(3)] Provide information regarding each instance in which you were charged by, or were the subject of an order by the Vermont Board of Medical Practice or other Vermont professional licensing authority, including the findings, conclusions, orders, and final disposition of the matter by the courts, if applicable.

Date	Final Disposition Summary
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43. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)] Have you ever been charged by, or been the subject of an order by a professional licensing or certification authority in any other US state or territory, or Canadian territory or province? (This includes stipulations, consent orders, or other voluntary resolutions that you accepted after being notified of an investigation, even if no charges were served.)

No

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

Provide information regarding each incident in which you have been charged by or been the subject of an order by a professional licensing or certification authority in any other state, territory, or province. Provide documentation that shows the charges, findings, conclusions, and orders, plus final disposition by any court or appeal authority, if appealed.

Date of Disposition	Licensing Authority	City	State	Description of Disposition
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Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)]

45. Have you ever had hospital privileges revoked or involuntarily restricted for reasons related to competence or character?

No

46.

A. Revocation or Restriction of Hospital Privileges Information

Provide information about each instance in which hospital privileges were revoked or involuntarily restricted for reasons related to competence or character. Provide documentation that shows the date, basis for the action, the authority who took the action, and the action taken.

Date of Restriction	Hospital Name	State	Nature of Restriction	Reason for Restriction
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47. Have you ever, after having been notified of an investigation or peer review that was not yet resolved, or in lieu of or in settlement of a pending disciplinary case related to competence or character, done any of the following:

resigned medical staff membership or privileges;

not renewed medical staff membership or privileges; or, -

consented to a restriction of hospital privileges?

No

48. B. Resignation or Nonrenewal of Medical Staff Membership, or Restriction of Privileges Information

Provide information about each instance in which you resigned or did not renew medical staff membership, or you had hospital privileges restricted, after having been notified of an investigation or peer review that was not yet resolved, or in lieu of or in settlement of a pending disciplinary case related to competence or character? Provide documentation that shows the date, the hospital, the basis for and nature of the case, and the terms of settlement, if any.

Date	Hospital Name	State	Action	Nature of Action	In Lieu or In Settlement
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Appointments/Teaching [See 26 VSA § 1368(a)(12)]

Note: answering the Appointments and Teaching questions 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.)

49.

A. Appointments

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

School	City	State	Nature of Position	Date Started	Date Ended
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50.

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	Date Started	Date Ended
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51. Publications [See 26 VSA § 1368(a)(13)]

Note: Answering this question is optional. By answering, you are granting permission to have this information posted on the web. Please provide information regarding your publication in peer-reviewed medical literature within the past 10 years.

Title	Publication	Publication Date
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52. Activities [See 26 VSA § 1368(a)(14)]

Note: Answering this question 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.

Activity or Award

Practice Plans and Residence<

53. When are you scheduled to begin work in Vermont?

As soon as possible. Will be doing telemedicine

54. Provide information about each current and planned practice location, wherever located. Indicate which is planned to be your primary Vermont practice location.

Practice Name	City	State	Primary Practice	Languages	Accepts Medicaid?	Accepts New Medicaid Patients?
98point6	Seattle	Washington	Yes		No	No

55. Brief description of your anticipated practice in Vermont:

98point6 physicians mainly use text-based communications with patients and have the ability to elevate to audio and video conferences. 98point6 physicians provide primary care services to patients remotely.

56. Provide information about each of your physical residences for the past ten years.

City	State	From	To
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Addendum 2

57. Have you ever applied for and been denied a license or certificate to practice medicine or any other healing art in any jurisdiction? If yes, identify the US state or territory, or Canadian territory or province that denied the application and the year in which it was denied, and provide a summary of the circumstances and reason for denial, in the following questions. Upload documents related to the denial where indicated.

No

58. State:

59. Year:

60. Circumstances under which you applied and were denied a certificate to practice medicine or any other healing art:

61. Denied certificate to practice medicine or any other healing art - Upload documents

62. Have you ever withdrawn an application for a license or certificate to practice medicine or any other healing art, in any jurisdiction? If yes, identify the US state or territory, or the Canadian territory or province in which you withdrew the application and the year in which it was withdrawn, and provide a summary of the circumstances and reason for the withdrawal, in the following questions. Upload documents related to the withdrawal where indicated.

No

63. State:

64. Year:

65. Circumstances under which the application for license or certificate was withdrawn, specifying your reason or reasons for withdrawal

66. Withdrawal of application for license or certificate - Upload documents:

67. Have you ever voluntarily surrendered a license or certificate to practice medicine or any other healing art, in any jurisdiction, after having been notified of an investigation that had not yet been resolved or in lieu of disciplinary action? "Surrendered a license" includes any form of voluntary abandonment of the right to practice in a jurisdiction, regardless of the terminology used, and includes allowing a license to lapse after learning of an investigation by a licensing authority. If yes, identify the state, territory, or province in which you surrendered a license or certificate and the year in which it was surrendered or you resigned, and provide a summary of the circumstances in the following questions. Upload documents related to the surrender of license where indicated. NOTE: If you let a license lapse because you no longer practiced in a state, and you had no knowledge of a pending investigation by the licensing authority, that would not constitute surrender of your license.

No

68. State:

69. Year:

70. Circumstances:

71. Voluntary surrendered license or certificate to practice medicine or any other healing art - Upload documents:

72. Are you currently the subject of any disciplinary charges by, or has disciplinary or employment action ever been taken by, any governmental authority, hospital, health care facility, or professional medical association, other than matters that have already been identified in response to preceding questions, or have you ever entered an "integrity agreement" with a governmental authority that related in any way to the practice of medicine? If yes, identify the entity bringing the charges or action, the date, the duration of any discipline or conditions, any action taken, and the circumstances in the following questions. Upload documents related to the charges or actions where indicated.

No

73. Name of entity involved:

74. Date:

75. Duration:

76. Action Taken (add all that apply):

77. Circumstances:

78. Disciplinary charges or actions - Upload documents:

79. Has any US or Canadian state, territorial, or provincial licensing board ever denied you the privilege of taking an examination to be licensed as a health care professional? If yes, identify the state, territory, or province that denied you the privilege and provide the circumstances of the denial in the following questions. Upload documents relating to the denial of the privilege of taking an examination where indicated.

No

80. State:

81. Circumstances surrounding denial of examination privileges and reason therefore provided by the board that denied you the privilege of taking an exam:

82. Denial of examination privileges - Upload documents:

83. Have you ever discontinued your education, training, or medical practice for a period of more than three (3) months, NOT including periods occurring solely during premedical education?

No

84. If yes, please explain, including the dates during which your education, training, or practice was discontinued.

85. Discontinued Education, Training, or Clinical Practice - Upload documents:

86. Have you ever been dismissed or suspended from, or asked to leave a training program before completion?

No

87. Training Program(s)

88. Location of Program(s)

89. Year:

90. Circumstances surrounding dismissal, suspension, or request for you to leave the training program(s) before completion?

91. Are you currently the subject of an investigation or peer review by any licensing authority, hospital, medical staff group, health care facility, professional association, or other body that has authority to take actions regarding: your right to practice medicine or any other healing art; your employment practicing medicine or any other healing art; or your professional qualifications (e.g., specialty board certification)? If yes, provide the name of the entity conducting the investigation, its location, the date you learned about the investigation, and the circumstances that triggered the investigation in the following questions and upload any relevant documentation you have such as a letter notifying you of the investigation where indicated.

92. Entity Investigating:

93. Location of entity investigating:

94. Date (month and year) you learned of the investigation?

95. Describe the event under investigation and the circumstances triggering the investigation:

96. Open investigation by licensing authority, hospital, medical staff group, health care facility, professional association, or professional certifying organization – upload documents.

97. Has your privilege to possess, dispense, administer, or prescribe controlled substances or other prescription medications or devices ever been suspended, revoked, denied, restricted, or surrendered as the result of an investigation or action by any governmental entity at any time? If yes, provide the entity that acted on your privilege to prescribe, the nature of the limitation or action, the date of the action, and a description of the circumstances underlying the action in the following questions, and upload any relevant documentation you have regarding the action where indicated.

No

98. Entity that took action on prescribing privileges:

99. Action taken:

100. Date of action taken regarding prescribing privileges:

101. Circumstances underlying action on prescribing rights:

102. Action taken on prescribing privileges – upload documents.

103. Are you presently a defendant in a criminal proceeding?

No

104. Court:

105. City and state:

106. Charge:

107. Description:

108. Status:

109. Date:

110. Defendant in criminal proceeding - Upload Documents:

111. Do you currently prescribe, or have you ever prescribed, prescription medication or devices solely in response to communication by computer or other electronic means? This does not include: initial admission orders for newly hospitalized patients; prescribing for patients of a physician for whom you have taken call; prescribing for a patient examined by a licensed advanced practice registered nurse or physician assistant, or other practitioner with whom you have a supervisory or collaborative relationship; continuing medication on a short-term basis for a new patient prior to the new patient's first appointment; or emergency situations in which the life or health of the patient is in imminent danger. Nor would this include the use of an electronic medical record or other system for entering and transmitting prescriptions.

Yes

112. If you answered yes to the preceding question, provide a general description of any prescribing you do in response to electronic communications.

113. Medical Malpractice Court Judgments & Settlements Have you ever had a medical malpractice claim against you that is still pending or that resulted in any of the following:

- a court judgment against you; or

- an arbitration award or a settlement that you or another party paid on your behalf?

If you have any such cases, you must provide information as requested in the questions below. You must also complete a Medical Malpractice Case Information Form for each. The form is located [here](#) Download the form, fill it out completely, and upload it where indicated. A form must be completed and submitted for each case. You must also provide documentation for each case as explained on the form.



114. A. Judgments

Provide the information requested in the following table for each case in which there was a court judgment or arbitration award against you.

Date of Judgment	Number of Judgments
------------------	---------------------

115. B. Settlements

Provide the information requested in the following table for each case in which you were named as a defendant and in which a settlement was paid by you or on your behalf.

Date Of Settlement

116. C. Pending Cases

Provide the information requested in the following table for each case that is currently pending against you.

Date

Addendum 3

Addendum 3

This information is confidential and is exempt from public disclosure.

117. To your knowledge, are you currently the subject of a criminal investigation that has not yet resulted in charges against you? If yes, provide the jurisdiction, a description of the matter under investigation, and the date you became aware of the investigation in the following questions.



118. Jurisdiction:

119. Description of matter under Investigation:

120. Date you became aware of Investigation:

121. Upload any documents you may have relating to the matter under investigation:

122. To your knowledge, are you the subject of an investigation by any other licensing or certification board that has not yet resulted in charges as of the date of this application? If yes, provide the board involved, the date you became aware of the investigation, and a description of the matter under investigation in the following questions and upload relevant documents where indicated.



123. Licensing or certification board conducting investigation:

124. Date of event(s) under investigation:

125. Nature of event(s) under investigation:

126. Pending licensing board investigation – upload documents.

127. **Investigation by other licensing or certification board - proceeding - Upload documents**

MEDICAL QUESTIONS

Please answer "Yes" or "No" to the questions below. Definitions are provided to assist you in answering. Please explain any "Yes" answers in Form A.

DEFINITIONS

In answering the following questions, please use these definitions:

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make 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 and 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 medical professional.

"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.

Medical condition, treatment, use of chemical or illegal substances:

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



129. If you answered yes to the preceding question please identify the impairment and explain how you address it in practice

130. Please upload any documents you have that are relevant to this matter.

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



132. If you answered yes to the preceding question please explain how you address it in order to practice with reasonable skill and safety.

133. Please upload any documents you have that are relevant to this matter.

134. Are you currently engaged in the illegal use of controlled substances?



135. In explaining a "Yes" answer to the previous question, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

136. Please upload any documents you have that are relevant to this matter.

137. Treating organization:

138. Address:

139. Telephone:

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

141. Dates of illness or dependency (from, to):

142. Dates of treatment (from, to):

143. Name of rehabilitation/professional assistance or monitoring program:

144. Address:

145. Telephone:

146. Contact person at Program:

Addendum 4

147.

Addendum 4

List of Three (3) References

Provide information about three physicians/Podiatrists who will provide references as to your moral character and professional competence. The Individuals providing references must hold a full, unrestricted license to practice medicine/podiatry. Note that the requirement in law is for a total of three references from the "chief of service and two other active physician/podiatric staff members at the hospital where the person was last affiliated." 26 V.S.A. § 1391(a). If you have not been affiliated with a hospital in recent years, or are otherwise unable to provide references from the three individuals

indicated above, contact us to get more information about appropriate references. References Must be from MD/DPM only. We cannot accept references from Osteopathic physicians. Your references must return the form directly to the Board.

If you are applying while still in a residency program or within a year of completing such a program, you should submit a letter from the program director in lieu of a letter from the chief of service.

Reference First Name	Reference Last Name	Address Line 1	Address Line 2	City	State	Zip Code	Phone Number	Email Address	Years Known	Organization/Title (ie. Program Director, Chief of Staff, Other Professional)
Michael	Grabinski	701 5th Ave STE 2300		Seattle	Washington	98104	(866) 657-7991	michael@98point6.com	.25	98point6 Medical Director
Amanda	Cuda	701 5th Ave STE 2300		Seattle	Washington	98104	(866) 657-7991	amanda@98point6.com	.25	98point6 Medical Director
Brad	Younggren	701 5th Ave STE 2300		Seattle	Washington	98104	(866) 657-7991	brad@98point6.com	.25	98point6 Chief of Medicine

148. Provide an explanation as to having never held hospital privileges:

Addendum 5

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer these questions.

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)

149. You must select 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.

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)

150. You must select 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.)

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.

151. Social Security Number:

██████████

152. Date of Birth:

██████████

153. 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.

Yes

154. Date:

11/07/2019

Addendum 6

155.

**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 either:

A. This does not apply to me because I don't have any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense, or

B. 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.

Yes

156. Date:

11/07/2019

Application Payment

157. You must choose one of the following payment options to complete your application. Note: Your application will NOT be processed by the Medical Board until payment is received. If you are a commissioned officer on active duty in the armed forces, you must submit a copy of your current active duty orders.

Credit Card

Review

State of Vermont
Department of Health
Vermont Board of Medical Practice
108 Cherry St-PO BOX 70
Burlington, VT 05402-0070
HealthVermont.gov

[phone] 802-657-4220
[fax] 802-657-4227

Agency of Human Services

01/08/2020

Jamie Michele Phifer

Re: Vermont Medical Licensure - 042.0014648

Dear Dr. Phifer

Congratulations on receiving a license to practice medicine in Vermont. The Vermont Board of Medical Practice granted you a Vermont medical license on 01/08/2020

Enclosed please find your physician license and information relevant to practice in Vermont. Please verify the information on your practitioner profile at the following site: <https://apps.health.vermont.gov/cavu/>. Your login and password information is:

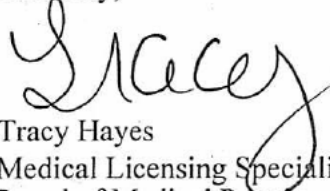
Username:

Password:

All medical licenses are renewed in November of every even year. You will receive a notification three months prior to the renewal date. Until that time, *licensees have a continuing obligation to promptly notify the Board of any change or new information including, but not limited to, change of address, disciplinary or other action limiting or conditioning their license or ability to practice in any jurisdiction. Failure to do so may subject the licensee to disciplinary action by the Board.*

If you have any questions or need additional information please do not hesitate to contact the Board.

Sincerely,



Tracy Hayes
Medical Licensing Specialist
Board of Medical Practice





Department of Health
Board of Medical Practice
108 Cherry Street - P.O. Box 70
Burlington, VT 05402-0070
healthvermont.gov

[phone] 802-657-4220
[toll free] 800-745-7371
[tty] 802-657-4227

Agency of Human Services

January 8, 2020

Jamie Phifer



Dear Dr. Phifer:

The Vermont Board of Medical Practice recently approved your application to practice medicine in Vermont. You are receiving this letter because the information you provided about where you would be practicing suggested that you might be using technology to provide medical care remotely using electronic means. When that is the case, the Board makes an effort to ensure that the new licensee is aware of the obligations associated with such practice.

The Board issued its *Policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine* on May 6, 2015. The policy can be found on the Board's website online at: http://healthvermont.gov/hc/med_board/documents/BoardPolicy_VermontTelemedicinePolicy_05062015.pdf. A 2015 Board Newsletter included an article about the newly-issued policy. It is at: http://healthvermont.gov/hc/med_board/documents/Newsletter_10162015_Telemedicine.pdf. The policy and article both refer to a provision in our law on unprofessional conduct that pertains to obligations of the physician when care is provided via electronic means. That provision, 26 V.S.A. § 1354(a)(33), is online at: <http://legislature.vermont.gov/statutes/section/26/023/01354>.

We wish you success in your practice and hope you find this information helpful.

A handwritten signature in dark ink, appearing to read "David K. Herlihy".

David K. Herlihy
Executive Director





*State of Vermont
Board of Medical Practice*

THIS IS TO CERTIFY

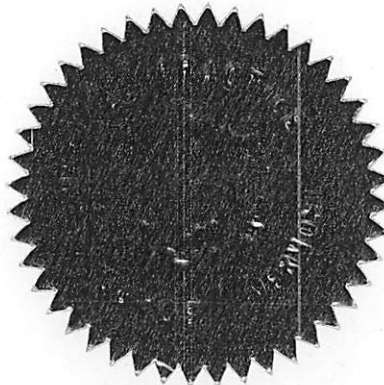
Jamie Michele Phifer, MD

*a graduate of
University of Florida, 2011*

*having successfully qualified as a practitioner of medicine before
this Board has been registered as provided by the Laws of the State.*

A handwritten signature in black ink, reading "Richard Bernstein, MD".

Chair: Richard Bernstein, MD



License Number 042.0014648

A handwritten signature in black ink, reading "Sarah McClain".

Vice-Chair: Sarah McClain
Burlington

Date: 01/08/2020

Received and duly recorded.
Vermont Department of Health

Application Information Report

NAME OF APPLICANT: Jamie Michele Phifer

CITY / STATE OF RESIDENCE: Seattle, WA

DATE OF BIRTH: [REDACTED]

MEDICAL SCHOOL: University of Florida - 05/14/2011

SPECIALTY: Family Practice - 06/25/2014

BOARD CERTIFIED?: Yes

PRACTICE LOCATION: 98point6

PRIMARY SUPERVISOR:

POST GRADUATE SCHOOL: Swedish Cherry Hill Family Medicine Residency - 06/21/2014

REFERENCES: Michael Grabinski (98point6 Medical Director)
Amanda Cuda (98point6 Medical Director)
Brad Younggren (98point6 Chief of Medicine)

OTHER STATE LICENSES: ~~FL~~ (Full), ~~IL~~ (Full), ~~KS~~ (Full), ~~MA~~ (Full), ~~MD~~ (Full), ~~NJ~~ (Full),
~~WA~~ (Full)

LAST 4 DIGITS OF SSN: 9454

EXAMS:

111 ok
11/13/19
jam

For State Board Use Only

Affidavit and Authorization for Release of Information

Applicant: In the presence of a notary public, sign this form with attached photo. If you are using FCVS for credentials verification, consider having that form notarized at the same time. Send the separate notarized FCVS form to FCVS. **Do not send this form to FCVS** as doing so will delay your licensure.

Send this form to the board you are applying to for licensure. Include all other required materials.
A directory of state medical and osteopathic boards is available at <http://www.fsmb.org/policy/contacts>.

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

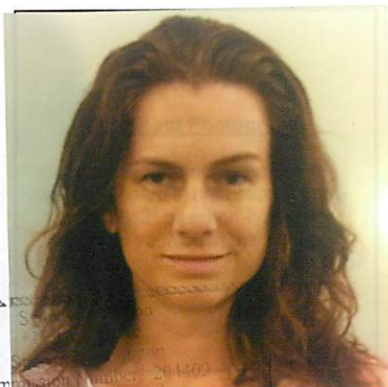
I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

RECEIVED

NOV 12 2019

**VERMONT BOARD OF
MEDICAL PRACTICE**



Applicant's signature (must be signed in the presence of a notary)

Phifer, Jamie Michele

Applicant's printed last name, first name, middle initial, and suffix (e.g., Jr.)

11-7-19

Date of signature (must correspond to date of notarization)

[Please note: The Notary Public seal should overlap the bottom of the photo to the left.]

NOTARY

Commission Expires
My Commission Expires
December 21, 2022

State of Washington, County of King

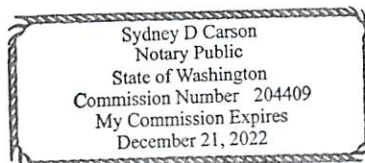
I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 7 day of November, 2019.

Notary Public Signature

[Signature]

My Notary Commission Expires 12-21-22



Jamie M Phifer, MD

206-743-7791 ♦ licensing-jamie.phifer@98point6.com

RECEIVED

NOV 12 2019

VERMONT BOARD OF
MEDICAL PRACTICE

EXPERIENCE

98point6, Telemedicine Physician. Seattle, WA. September
September 2019 - present

Swedish Medical Group, Primary & Urgent Care Physician. Seattle, WA. August
August 2014-present

EDUCATION

Swedish Cherry Hill Family Medicine Residency; Seattle, WA

June 2011 - June 2014

Carolyn Downs FQHC Site - Culturally competent primary care to majority underserved
African American, Latino and diverse immigrant population

University of Florida College of Medicine; Gainesville, FL

August 2007 - May 2011

Doctor of Medicine, Cum laude

University Florida College of Liberal Arts and Sciences; Gainesville, FL

August 2003 - May 2007

Bachelor of Science in Interdisciplinary Studies: Microbiology with a focus in
Entrepreneurship, Summa cum laude

Jamie Phifer
11-7-19

Hayes, Tracy

From: Jamie Phifer <licensing-jamie.phifer@98point6.com>
Sent: Thursday, November 7, 2019 3:59 PM
To: Hayes, Tracy
Subject: Re: Omission on Vermont Application

Hi Tracy,

So sorry about that. I work for 98point6, a telemedicine company that mainly uses text-based communications with patients (we also have the ability to elevate to audio and video conferences). As a result, I prescribe in response to electronic communications.

Please let me know if you have any other questions!

Thank you.

On Thu, Nov 7, 2019 at 12:14 PM Hayes, Tracy <Tracy.Hayes@vermont.gov> wrote:

Hi,

You said yes to the following question but did not include the explanation. Please provide. Thanks.

Tracy

111. Do you currently prescribe, or have you ever prescribed, prescription medication or devices solely in response to communication by computer or other electronic means? This does not include: initial admission orders for newly hospitalized patients; prescribing for patients of a physician for whom you have taken call; prescribing for a patient examined by a licensed advanced practice registered nurse or physician assistant, or other practitioner with whom you have a supervisory or collaborative relationship; continuing medication on a short-term basis for a new patient prior to the new patient's first appointment; or emergency situations in which the life or health of the patient is in imminent danger. Nor would this include the use of an electronic medical record or other system for entering and transmitting prescriptions.

Yes

112. If you answered yes to the preceding question, provide a general description of any prescribing you do in response to electronic communications.

Tracy Hayes



PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

New Jersey Office of the Attorney

Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183, Trenton, NJ 08625-0183



GURBIR S. GREWAL
Attorney General

PAUL R. RODRIGUEZ
Acting Director

Vermont Board of Medical Practice
P.O. Box 70
Burlington, VT 05402-0070

October 28, 2019
RECEIVED

NOV - 1 2019

**VERMONT BOARD OF
MEDICAL PRACTICE**

For Delivery Services:
140 East Front St.
PO Box 183 2nd Floor
Trenton, NJ 08608
(609) 826-7100
(609) 777-0956 FAX

To Whom It May Concern:

The New Jersey State Board of Medical Examiners has been requested by JAMIE PHIFER to forward a letter of good standing regarding the Medical Doctor's license to practice in the State of New Jersey.

A review of the Board's files indicates that JAMIE PHIFER was issued a New Jersey license 25MA10601400 on or about 05/21/2019 and is currently Active with an expiration date of 06/30/2021. A review of the Board's files further indicates that no public disciplinary action has been taken against this Medical Doctor.

Very truly yours,
BOARD OF MEDICAL EXAMINERS

William V. Roeder
Executive Director

WVR/sdp



Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

JB Pritzker
Governor

Deborah Hagan
Secretary

Cecilia Abundis
Acting Director
Division of
Professional
Regulation

CERTIFICATION OF LICENSURE

Licensee: License Jamie Phifer MD
Number: 036.150427
Profession: LICENSED PHYSICIAN AND SURGEON
Date of Issuance: 08/07/2019
Expiration Date: 07/31/2020
License Status: ACTIVE
License Method: ENDORSEMENT
Disciplinary History: Has not been disciplined

This document is a certified copy of the records maintained and kept by this department in the regular course of business as of 10/11/2019

Cecilia Abundis
Acting Director

Division of Professional Regulation

10/11/2019

Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.



Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

JB Pritzker
Governor

Deborah Hagan
Secretary

Cecilia Abundis
Acting Director
Division of
Professional
Regulation

CERTIFICATION OF LICENSURE

[REDACTED]

Licensee: License Jamie Phifer MD
Number: 036.150427
Profession: LICENSED PHYSICIAN AND SURGEON
Date of Issuance: 08/07/2019
Expiration Date: 07/31/2020
License Status: ACTIVE
License Method: ENDORSEMENT
Disciplinary History: Has not been disciplined

This document is a certified copy of the records maintained and kept by this department in the regular course of business as of 10/11/2019

Cecilia Abundis
Acting Director

Division of Professional Regulation

10/11/2019

Date

Refer to the Department's Web Site at www.idfpr.com to verify professional licenses via License Look-Up.

Mission:

To protect, promote & improve the health
of all people in Florida through
integrated state, county, & community



Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the Healthiest State in the Nation

October 11, 2019

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

RE: License Certification for Jamie Michele Phifer

To Whom It May Concern:

This is to certify the following information, maintained in the records of the Department of Health, for the
above referenced Health Care Practitioner:

PROFESSION:	Medical Doctor
LICENSE NUMBER:	ME125540
ORIGINAL CERTIFICATION:	09/08/2015
EXPIRATION DATE:	01/31/2020
CURRENT STATUS OF LICENSE:	CLEAR, ACTIVE
AGENCY ACTION:	None

This license information was last updated on: 10/11/2019

To expedite the verification process, the above format is the standard format for all healthcare
practitioners. If you have questions regarding the status of this license, please call the Customer Contact
Center at (850) 488-0595.



Florida Department of Health
Division of Medical Quality Assurance
4052 Bald Cypress Way, Bin C-10 / Tallahassee, FL 32399
PHONE: 850/488-0595 / FAX: 850/487-9626
FloridaHealth.gov



Accredited Health Department
Public Health Accreditation Board



October 11, 2019

VERMONT BOARD OF MEDICAL PRACTICE
P O BOX 70
BURLINGTON, VT 05402

Subject: Credential Verification

To Whom It May Concern:

This verifies the status of the Physician And Surgeon License for JAMIE MICHELE PHIFER.

You may see blank sections because we do not have the information in our database or it is not applicable for this credential type. This information is valid from the date of this letter.

Year of Birth:	██████████
Credential Number:	MD.MD.60359609
Credential Type:	Physician And Surgeon License
Current Credential Status:	ACTIVE
First Credential Date:	07/05/2013
Current Expiration Date:	08/25/2020
Last Renewal Date:	07/30/2018
DISCIPLINARY ACTION:	No



WASHINGTON
**Medical
Commission**
Licensing. Accountability. Leadership.

October 11, 2019

VERMONT BOARD OF MEDICAL PRACTICE
P O BOX 70
BURLINGTON, VT 05402

Subject: Credential Verification

To Whom It May Concern:

This verifies the status of the Physician And Surgeon Residency License for JAMIE MICHELE PHIFER.

You may see blank sections because we do not have the information in our database or it is not applicable for this credential type. This information is valid from the date of this letter.

Year of Birth:	██████████
Credential Number:	MDRE.ML.60224778
Credential Type:	Physician And Surgeon Residency License
Current Credential Status:	CLOSED
First Credential Date:	06/14/2011
Current Expiration Date:	07/05/2013
Last Renewal Date:	06/11/2012
DISCIPLINARY ACTION:	No

This license information was last updated on: 10/11/2019

If you have questions, please call (360)-236-2750 or visit our Online Provider Credential Search at <https://wmc.wa.gov>



Kimberly M. Romero, Licensing Manager

Kansas State Board of Healing Arts
800 SW Jackson, Suite A-Lower Level
Topeka, KS 66612



Phone: 785-296-7413
1-888-886-7205
Fax: 785-296-0852
www.ksbha.org

Kathleen Selzler Lippert
Executive Director

Sam Brownback, Governor

October 11, 2019

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

This is to certify that: Jamie Michele Phifer has been licensed to practice in Kansas in the following profession: Medical Doctor (MD)

License Number:	04-40305
Date of Birth:	[REDACTED]
Profession:	Medical Doctor (MD)
License Status:	Cancelled - Failure to Renew
Original License Date:	08/11/2017
License Cancellation Date:	07/31/2018

Disciplinary Action: None

This license information was last updated on: 10/10/2019

Unless otherwise indicated, this licensee has not been subject to disciplinary proceeding by the Kansas Board of Healing Arts.

Verified by:

Nichole Schlesener
Licensing Manager/Administrator
Kansas State Board of Healing Arts
800 SW Jackson, Lower Level-Suite A
Topeka, KS 66612
785-296-1386 (phone)



MARYLAND Department of Health Board of Physicians

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

October 15, 2019

Vermont Board of Medical Practice

108 Cherry Street

P.O. Box 70

Burlington

VT 05402-0070

This is to verify the records of the Maryland Board of Physicians. The following information is available under the Maryland Public Information Act, State Government Article, Section 4-333, regarding the following practitioner:

Jamie Michele Phifer

For the Practice of:	Physician-M.D.
License Number:	D87604
Date Issued:	05/30/2019
Current Status:	Active
Expiration Date	09/30/2021
*Disciplinary Actions	No disciplinary actions.

*Disciplinary information can be found on our website. Go to <https://www.mbp.state.md.us> and select Lookup a License.

For malpractice claim information, please contact the Maryland Health Care Alternative Dispute Resolution Office 410.767.8200.

Respectfully,

Maryland Board of Physicians
Verification Unit





Commonwealth of Massachusetts Board of Registration in Medicine

200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

www.mass.gov/massmedboard

Enforcement Division

Legal Division

Licensing Division

Fax: (781) 876-8381

Fax: (781) 876-8380

Fax: (781) 876-8383

CANDACE LAPIDUS SLOANE, MD
Chair, Physician Member

GEORGE ABRAHAM, MD
Vice Chair, Physician Member

JULIAN N. ROBINSON, MD
Secretary, Physician Member

WOODY GIESSMANN, LADC-I, CADAC, CIP, CAI
Public Member

MICHAEL D. MEDLOCK, MD
Physician Member

PAUL G. GITLIN, ESQ
Public Member

GEORGE ZACHOS, ESQ.
Executive Director

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary
Health and Human Services

MONICA BHAREL, MD, MPH
Commissioner
Department of Public Health

RECEIVED

OCT 21 2019

VERMONT BOARD OF
MEDICAL PRACTICE

10/16/2019

To Whom It May Concern:

This certifies that Jamie M Phifer, M.D., a 2011 graduate of University of Florida College of Medicine, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 281320 was issued to Dr. Phifer on 09/26/2019. The license status is: Active. The expiration date is 8/25/2020.

Listed below is certain complaint and disciplinary information on this physician. Please note that the Board can neither confirm nor deny the existence of open complaints.

Closed Complaint Information

Our files contain 0 closed complaint(s) on this physician.

Final Board Disciplinary Action

Our files contain 0 disciplinary action(s) taken against this physician by the Board.

This information is derived from Board files from January 1, 1987 to the present. It does not include all the information contained in a license application.

As a service to the public and to designated agencies, the Massachusetts Board of Registration in Medicine offers an online profile of all physicians with full licenses who are licensed in the Commonwealth. This profile is updated daily and may include public information that is not otherwise contained in this certification letter. You may access this information at the Board's website:

www.mass.gov/massmedboard

Finally, the Board tallies closed complaints separately from disciplinary actions. If the same underlying incident gives rise to both a complaint and a disciplinary action, the Board counts this as two separate actions. In the same way, multiple disciplinary actions are tallied separately, even if they arise from a single set of circumstances.

SEAL

Staff Member, Board of Registration in Medicine

Tammi McManus



American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

August 14, 2019

To Whom It May Concern:

This letter verifies Jamie Phifer, M.D. (NPI: 1154615185) is currently certified with the American Board of Family Medicine (ABFM).

Family Medicine Certification History:

Jun 25, 2014 - *

Certification Number: 1028431249

* Certification is continuous as long as Family Medicine Certification Requirements are maintained.

Family Medicine Certification Requirements:

Current Status:



Meeting Requirements

Current Clinical Status:

Clinically Active

Clinical Status History:

Jun 28, 2018 -

Clinically Active

Initial display of clinical status began June 2018 and history is only shown for certified periods.

Beginning in 2011 certification by the American Board of Family Medicine is maintained through successful completion of the Family Medicine Certification process. The Family Medicine Certification process is a continuous process that requires being in compliance with Guidelines for Professionalism Licensure and Personal Conduct including maintaining a currently valid, full, and unrestricted license to practice medicine in the United States or Canada, completing certification activities in a timely fashion, and performing successfully on the examination every ten years. Failure to maintain any of these requirements will result in the loss of certification status with the ABFM. Based upon the continuous nature of Family Medicine Certification, no end date for certification is presented above.

The ABFM website serves as primary source verification. Details of the Family Medicine Certification process are available online at www.theabfm.org

Sincerely,

Mary McIntosh

Verification Coordinator and Candidate Assistant

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

RECEIVED
NOV 18 2019
VERMONT BOARD OF
MEDICAL PRACTICE

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER

Name of applicant: Jamie Phifer

The Applicant named above has applied to the Vermont Board of Medical Practice for a license to practice medicine. 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.

Name Jamie Phifer was at 98point6

From September 2019 to present. During that time, he/she

Was (List status in the institution): Telemedicine Physician

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.

The basic medical knowledge:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Professional judgement:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Sense of responsibility:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Moral character/ethical conduct:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Competence and skill:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Cooperativeness ability to work with others:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
History & physical exam taking:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Record keeping:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Patient management:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Case presentations:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Physician-Patient relationship:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Participation in Medical Staff Affairs:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average

Name of applicant: Jamie Phifer

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 as a physician's assistant?

☐ 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 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 concern (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 consultants when needed?

☒ Yes ☐ No

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicants medical education. Please check the appropriate response. If you answer yes to any of these questions, please enclose an explanation.

Did the applicant take any leaves of absence or breaks from his/her medical education?

☐ Yes ☒ No

Were any limitations or special requirements imposed on the applicant because of questions of academic or technical competence?

☐ 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 applicant 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 previous evaluations

☐ Other – Specify: _____

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

I recommend Jamie Phifer for licensure in Vermont.

Signed: Amanda Cuda Date: 11/12/2019

Print or Type Name and Title: Amanda Cuda, MD -- Medical Director

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

RECEIVED

NOV 18 2019

VERMONT BOARD OF
MEDICAL PRACTICE

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER

Name of applicant: Jamie Phifer

The Applicant named above has applied to the Vermont Board of Medical Practice for a license to practice medicine. 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.

Name Jamie Phifer was at 98point6

From September 2019 to present. During that time, he/she

Was (List status in the institution): Telemedicine Physician

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.

The basic medical knowledge:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Professional judgement:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Sense of responsibility:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Moral character/ethical conduct:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Competence and skill:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Cooperativeness ability to work with others:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
History & physical exam taking:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Record keeping:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Patient management:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Case presentations:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Physician-Patient relationship:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Participation in Medical Staff Affairs::	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average

Name of applicant: Jamie Phifer

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 as a physician's assistant?

☐ 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 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 concern (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

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicants medical education. Please check the appropriate response. If you answer yes to any of these questions, please enclose an explanation.

Did the applicant take any leaves of absence or breaks from his/her medical education?

☐ Yes ☒ No

Were any limitations or special requirements imposed on the applicant because of questions of academic or technical competence?

☐ 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 applicant 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 previous evaluations

☐ Other – Specify: _____

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

I recommend Jamie Phifer for licensure in Vermont.

Signed: _____

Date: 11/13/19

Print or Type Name and Title: Brad Younggren, MD -- Chief Medical Officer

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

RECEIVED

NOV 18 2019

VERMONT BOARD OF
MEDICAL PRACTICE

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER

Name of applicant: Jamie Phifer

The Applicant named above has applied to the Vermont Board of Medical Practice for a license to practice medicine. 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.

Name Jamie Phifer was at 98point6

From September 2019 to present. During that time, he/she

Was (List status in the institution): Telemedicine Physician

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.

The basic medical knowledge:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input checked="" type="checkbox"/> Average	<input type="checkbox"/> Above Average
Professional judgement:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Sense of responsibility:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Moral character/ethical conduct:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Competence and skill:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Cooperativeness ability to work with others:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input checked="" type="checkbox"/> Average	<input type="checkbox"/> Above Average
History & physical exam taking:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input checked="" type="checkbox"/> Average	<input type="checkbox"/> Above Average
Record keeping:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input checked="" type="checkbox"/> Average	<input type="checkbox"/> Above Average
Patient management:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Case presentations:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input checked="" type="checkbox"/> Average	<input type="checkbox"/> Above Average
Physician-Patient relationship:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average
Participation in Medical Staff Affairs::	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input checked="" type="checkbox"/> Average	<input type="checkbox"/> Above Average
Competence in being able to communicate in reading, writing and speaking the English language:	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Average	<input checked="" type="checkbox"/> Above Average

Name of applicant: Jamie Phifer

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 as a physician's assistant?

☐ 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 is not minor)

☐ Yes ☒ No

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☐ Yes ☒ No

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☐ Yes ☒ No

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☐ 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 consultants when needed?

☒ Yes ☐ No

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please check the appropriate response. If you answer yes to any of these questions, please enclose an explanation.

Did the applicant take any leaves of absence or breaks from his/her medical education?

☐ Yes ☒ No

Were any limitations or special requirements imposed on the applicant because of questions of academic or technical competence?

☐ Yes ☒ No

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The above report is based on:

☒ Close personal observation

☐ General impression

☐ A composite of previous evaluations

☐ Other - Specify: _____

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

I recommend Jamie Phifer for licensure in Vermont.

Signed: _____

Date: _____

Print or Type Name and Title: Martin Maimon, MD -- Associate Medical Director

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

RECEIVED

NOV 25 2019

VERMONT BOARD OF
MEDICAL PRACTICE

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER

Name of applicant: Jamie Phifer

The Applicant named above has applied to the Vermont Board of Medical Practice for a license to practice medicine. 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.

Name Jamie Phifer was at Swedish Medical Group

From August 2016 to present. During that time, he/she

She is also a Telemedicine Physician with me at 98point6 (from Sept 2019 - present)

Was (List status in the institution): a Primary & Urgent Care Physician

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.

The basic medical knowledge: ☐ Poor ☐ Fair ☐ Average ☒ Above Average

Professional judgement: ☐ 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

Patient management: ☐ Poor ☐ Fair ☐ Average ☒ Above Average

Case presentations: ☐ Poor ☐ Fair ☐ Average ☒ Above Average

Physician-Patient relationship: ☐ Poor ☐ Fair ☐ Average ☒ Above Average

Participation in Medical Staff Affairs: ☐ Poor ☐ Fair ☐ Average ☒ Above Average

Competence in being able to communicate in reading, writing and speaking the English language: ☐ Poor ☐ Fair ☐ Average ☒ Above Average

Name of applicant: Jamie Phifer

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 as a physician's assistant?

☐ 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 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 concern (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

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicants medical education. Please check the appropriate response. If you answer yes to any of these questions, please enclose an explanation.

Did the applicant take any leaves of absence or breaks from his/her medical education?

☐ Yes

☒ No

Were any limitations or special requirements imposed on the applicant because of questions of academic or technical competence?

☐ 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 applicant 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 previous evaluations

☐ Other – Specify: _____

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

I recommend Jamie Phifer for licensure in Vermont.

Signed:  Date: 11/22/19

Print or Type Name and Title: Andrew Le, MD

DEC - 2 2019

VERMONT BOARD OF
MEDICAL PRACTICE

REFERENCE FORM TO BE COMPLETED BY AN ACTIVE PHYSICIAN STAFF MEMBER

Name of applicant: Jamie Phifer

The Applicant named above has applied to the Vermont Board of Medical Practice for a license to practice medicine. 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.

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Name Jamie Phifer was at Swedish Medical Group

From August 2014 to present. During that time, he/she

Was (List status in the institution): a Primary & Urgent Care Physician

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.

The basic medical knowledge: ☐ Poor ☐ Fair ☐ Average ☒ Above Average

Professional judgement: ☐ 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

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Record keeping: ☐ Poor ☐ Fair ☐ Average ☒ Above Average

Patient management: ☐ Poor ☐ Fair ☐ Average ☒ Above Average

Case presentations: ☐ Poor ☐ Fair ☐ Average ☒ Above Average

Physician-Patient relationship: ☐ Poor ☐ Fair ☐ Average ☒ Above Average

Participation in Medical Staff Affairs: ☐ Poor ☐ Fair ☐ Average ☒ Above Average

Competence in being able to communicate in reading, writing and speaking the English language: ☐ Poor ☐ Fair ☐ Average ☒ Above Average

Name of applicant: Jamie Phifer

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 as a physician's assistant?

☒ 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 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 concern (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

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicants medical education. Please check the appropriate response. If you answer yes to any of these questions, please enclose an explanation.

Did the applicant take any leaves of absence or breaks from his/her medical education?

☐ Yes

☒ No

Were any limitations or special requirements imposed on the applicant because of questions of academic or technical competence?

☐ 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 applicant 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 previous evaluations

☐ Other - Specify: _____

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

I recommend Jamie Phifer for licensure in Vermont.

Signed: Jodie Wohl, MD Date: 11/22/19

Print or Type Name and Title: Jodie Wohl, MD

The University of Florida

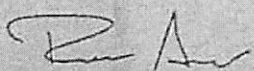
has conferred on
Jamie Michele Phifer
the degree

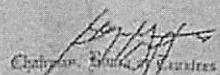
Doctor of Medicine

and all the rights and privileges thereunto appertaining.
In Witness Whereof, this diploma, duly signed, has been issued
and the seal of the University affixed.

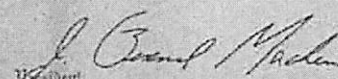
Issued by the Board of Trustees upon recommendation of the Faculty of
The College of Medicine
at Gainesville, this fourteenth day of May, 2011.

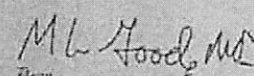
SEAL
VERIFIED

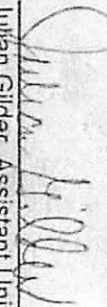

Governor


Chairman, Board of Trustees




President


Dean


Julian Gilder, Assistant University Registrar
College of Medicine University of Florida
November 20, 2018

I certify that this is a true and correct copy of the diploma presented to Jamie Michele Phifer at the University of Florida College of Medicine on May 14, 2011.

215 785 155

Swedish Medical Center

Cherry Hill
Seattle, Washington

This Certifies That

Jamie M. Phifer, M.D.

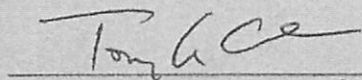
has faithfully and satisfactorily performed the duties of

Family Medicine Resident

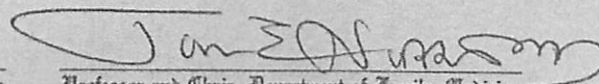
from

June 21, 2011 to June 24, 2014

In witness whereof, the undersigned have affixed their signatures



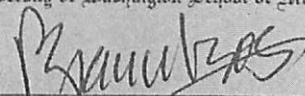
Chief Executive



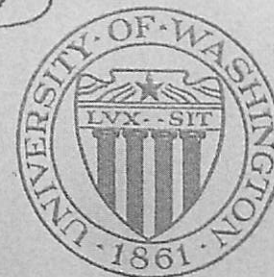
Professor and Chair, Department of Family Medicine
University of Washington School of Medicine



Administrative Director
Medical Education and Medical Staff Services



Director, Family Medicine Residency



An Approved Residency in Family Medicine
Affiliated with the University of Washington School of Medicine



United States Medical Licensing Examination® (USMLE®) Certified Transcript of Scores

This document was prepared by
Federation of State Medical Boards of the United States, Inc. (FSMB)
400 Fuller Wiser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Date: 10/18/2019

Federation Credentials Verification Service

ATTN: FCVS

FCV SID: 482434

Examinee: Phifer, Jamie Michele

Alt Name(s):

Examinee ID: 5-231-547-0

Date of Birth: [REDACTED]

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/30/2009	Pass	243	(185)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/28/2010	Pass	260	(189)	

Clinical Skills (CS)

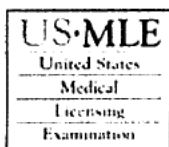
Test Date	Pass/Fail	Comments
09/03/2010	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
05/07/2013	Pass	214	(190)	

End of Exam History

NOTE: A search of the Physician Data Center of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.



United States Medical Licensing Examination® (USMLE®) Certified Transcript of Scores

This document was prepared by
Federation of State Medical Boards of the United States, Inc. (FSMB)
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Examinee: Phifer, Jamie Michele

Examinee ID: 5-231-547-0

Date of Birth: [REDACTED]

INTERPRETATION OF RESULTS

USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 2 CLINICAL SKILLS (CS)

Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

ANNOTATIONS APPEARING UNDER "COMMENTS"

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

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. No score is reported. Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript 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 for Individualized Review 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 transcript, it may be obtained by contacting the organization from which you received the transcript 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.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript 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.

PHYSICIAN DATA CENTER INFORMATION APPEARING AS "NOTE"

The Physician Data Center of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, the U.S. Department of Health and Human Services, government regulatory entities and international licensing authorities. To be included in the Physician Data Center, 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 Physician Data Center are not 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 the USMLE transcript by a Note.

03/2015

This document was printed from a secure website and accurately reflects score information maintained by the FSMB.

Renewal - 042.0014648

Name	Jamie Michele Phifer
Credential	042.0014648

Fee Details

Renewal Fee	\$525.00
	\$525.00

Renewal Introduction

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICAL PRACTICE
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070
(802)657-4223 or 800-745-7371

PHYSICIAN'S LICENSE RENEWAL APPLICATION**PART I**

Please follow the instructions below and submit the completed application with documentation and payment to this office. If you have any questions or need additional information do not hesitate to contact us at 802-657-4223, 800-745-7371 or AHS.VDHMedicalBoard@vermont.gov.

IMPORTANT: Your license will lapse if we have not received your completed application and fee by your expiration date. In addition, you will be subject to late renewal penalty fees and potentially liability if you practice medicine without a license.

INSTRUCTIONS

- do not delegate this important task to any other person. False statements on this application may be grounds for charges of unprofessional conduct.
- enter, correct or update all information
- answer all questions completely, even if you believe the information is already on file with the Board
- use the malpractice reporting forms from our website to provide explanations to Malpractice

Malpractice Claim Documentation – If you have reportable malpractice history, you must download the two page malpractice reporting forms found on our website, carefully complete a form for each case, and submit it along with the required documentation. For your application, reportable malpractice includes :

- Pending claims that have not been resolved.
- Cases that resulted in a payment by you or on your behalf, whether as a settlement, arbitration award, or court verdict.
- Note that you need not report cases that were resolved in your favor with no payment by you or on your behalf. This includes cases that were withdrawn without payment, dismissed without payment, or resolved by a verdict in your favor.
- Note: that you also do not need to provide information about your malpractice history previously provided to the Board. Your application has been pre-populated with information provided by and previously approved by you prior to the initial release of the Department's physician profiles. You only need to correct any factual inaccuracies and/or update any information as appropriate.

Be sure to submit:

- completed Form A, if applicable
- payment in the amount of \$525 to the **Vermont Department of Health**
- **LATE FEE:** Applications received after the license expiration date will be assessed a \$25 late fee.

Please Note:

- Your Physician License Renewal Application has been pre-populated with information provided by and previously approved by you prior to the initial release of the Department's physician profiles. Please take this opportunity to correct any factual inaccuracies and/or update any information as appropriate.
- Licensees have a continuing obligation during each two-year renewal period to promptly notify the Board of any change or new information including, but not limited to, disciplinary or other action limiting or conditioning their license or ability to practice in any jurisdiction. Failure to do so may subject the licensee to disciplinary action by the Board.

Thank you.

Renewal Part I

Name:

Indicate your full legal name (use no initials). If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Last Name:

Phifer

2. First Name:

Jamie

3. Middle Name:

Michele

4. Have you ever legally changed your name?

No

5. If yes, enter your former name and other name(s):

Previous Name	From Month	From Year	To Month	To Year	Reason for Change
			November	2019	
			November	2019	

6. Date of Birth:

[REDACTED]

7. Please provide your preferred email address for receiving important correspondence from this medical board

licensing-jamie.phifer@98point6.com

8. Enter your MAILING ADDRESS information:**Attention** 98point6**Address 1** 701 5th Ave STE 2300**Address 2****City** Seattle**State** WA**Zip** 98104**Country** United States**Email Address** licensing-jamie.phifer@98point6.com**Telephone Number** (866) 657-7991**Alternate Phone
Number**9. Enter your PUBLIC ACCESS address information:**Attention** 98point6**Street** 701 5th Ave STE 2300**City** Seattle**State** WA**Zip** 98104**Country** United States**Renewal Part II**

10. Do you have, or have you ever had, a Drug Enforcement Agency (DEA) Registration Number that allows you to prescribe controlled substances?

Yes

11. Enter each active DEA Registration Number:

[REDACTED]

12. Were you in active clinical practice in the past 12 months?

Yes

13. Do you hold, or have you ever held, a license or certification as a medical practitioner in any other state?

Yes

14. If yes, complete the section below.

State	Profession	License Number	Issue Date	Expiration Date	Status
Illinois	MD	036150427	08/07/2019	07/31/2023	Active
Massachusetts	MD	281320	09/26/2019	08/25/2022	Active
Washington	MD	MD60359609	07/05/2013	08/25/2022	Active
Florida	MD	ME125540	09/08/2015	01/31/2022	Active
Kansas	MD	04-40305	08/11/2017	07/31/2021	Active
New Jersey	MD	25MA10601400	05/21/2019	06/30/2021	Active
Maryland	MD	D87604	05/30/2019	09/30/2021	Active

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

Please provide the names of medical professional schools you attended and the dates of graduation.

School	Graduation Date
School Name: University of Florida School Type: Medical School Country: United States State: Florida Degree: MD	05/14/2011

16. 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.

Site Name	End Date	Specialty
Swedish Cherry Hill Family Medicine Residency	06/21/2014	Family Practice

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

Please verify the following information regarding your specialty board certification and update as necessary.

Specialty	Certification Board	Certification Date	Specialty Expiration Date
Family Practice	American Board of Family Medicine	06/25/2014	06/25/2024

18. Years of Practice

What year did you start practicing as a medical professional?

2011

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

List all hospitals where you currently have hospital staff privileges:

Facility Name	State	Start Date	End Date
---------------	-------	------------	----------

ANY "YES" RESPONSE TO THE QUESTIONS BELOW MUST BE FULLY EXPLAINED.

20. Has your driver's license ever been suspended or conditioned as a result of either (a) a refusal to provide a sample of breath or blood upon request by a law enforcement office; or (b) a civil (non-criminal) process for driving under the influence of drugs or alcohol? If you answer yes, please email an explanation and documents regarding the action.

No

21. Have you ever applied for and been denied a license or certificate to practice medicine or any other healing art in any jurisdiction? If yes, identify the US state or territory, or Canadian territory or province that denied the application and the year in which it was denied, and provide a summary of the circumstances and reason for denial, in the following questions. Upload documents related to the denial where indicated.

No

22. State:

23. Year:

24. Circumstances under which you applied and were denied a certificate to practice medicine or any other healing art:

25. Denied certificate to practice medicine or any other healing art - Upload documents

26. Have you ever withdrawn an application for a license or certificate to practice medicine or any other healing art, in any jurisdiction? If yes, identify the US state or territory, or the Canadian territory or province in which you withdrew the application and the year in which it was withdrawn, and provide a summary of the circumstances and reason for the withdrawal, in the following questions. Upload documents related to the withdrawal where indicated.

No

27. State:

28. Year:

29. Circumstances under which the application for license or certificate was withdrawn, specifying your reason or reasons for withdrawal

30. Withdrawal of application for license or certificate - Upload documents:

31. Have you ever voluntarily surrendered a license or certificate to practice medicine or any other healing art, in any jurisdiction, after having been notified of an investigation that had not yet been resolved or in lieu of disciplinary action? "Surrendered a license" includes any form of voluntary abandonment of the right to practice in a jurisdiction, regardless of the terminology used, and includes allowing a license to lapse after learning of an investigation by a licensing authority. If yes, identify the state, territory, or province in which you surrendered a license or certificate and the year in which it was surrendered or you resigned, and provide a summary of the circumstances in the following questions. Upload documents related to the surrender of license where indicated. NOTE: If you let a license lapse because you no longer practiced in a state, and you had no knowledge of a pending investigation by the licensing authority, that would not constitute surrender of your license.

No

32. State:

33. Year:

34. Circumstances:

35. Voluntary surrendered license or certificate to practice medicine or any other healing art - Upload documents:

36. Are you currently the subject of any disciplinary charges by, or has disciplinary or employment action ever been taken by, any governmental authority, hospital, health care facility, or professional medical association, other than matters that have already been identified in response to preceding questions, or have you ever entered an "integrity agreement" with a governmental authority that related in any way to the practice of medicine? If yes, identify the entity bringing the charges or action, the date, the duration of any discipline or conditions, any action taken, and the circumstances in the following questions. Upload documents related to the charges or actions where indicated.

No

37. Name of entity involved:

38. Date:

39. Duration:

40. Action Taken (add all that apply):

41. Circumstances:

42. Disciplinary charges or actions - Upload documents:

43. Has any US or Canadian state, territorial, or provincial licensing board ever denied you the privilege of taking an examination to be licensed as a health care professional? If yes, identify the state, territory, or province that denied you the privilege and provide the circumstances of the denial in the following questions. Upload documents relating to the denial of the privilege of taking an examination where indicated.

No

44. State:

45. Circumstances surrounding denial of examination privileges and reason therefore provided by the board that denied you the privilege of taking an exam:

46. Denial of examination privileges - Upload documents:

47. Have you ever discontinued your education, training, or medical practice for a period of more than three (3) months, NOT including periods occurring solely during premedical education?

No

48. If yes, please explain, including the dates during which your education, training, or practice was discontinued.

49. Discontinued Education, Training, or Clinical Practice - Upload documents:

50. Have you ever been dismissed or suspended from, or asked to leave a training program before completion?

No

51. Training program(s):

52. Location of program(s):

53. Year:

54. Circumstances surrounding dismissal, suspension, or request for you to leave the training program(s) before completion?

55. Are you currently the subject of an investigation or peer review by any licensing authority, hospital, medical staff group, health care facility, professional association, or other body that has authority to take actions regarding: your right to practice medicine or any other healing art; your employment practicing medicine or any other healing art; or your professional qualifications (e.g., specialty board certification)? If yes, provide the name of the entity conducting the investigation, its location, the date you learned about the investigation, and the circumstances that triggered the investigation in the following questions and upload any relevant documentation you have such as a letter notifying you of the investigation where indicated.

■

56. Entity Investigating:

57. Location of entity investigating:

58. Date (month and year) you learned of the investigation?

59. Describe the event under investigation and the circumstances triggering the investigation:

60. Open investigation by licensing authority, hospital, medical staff group, health care facility, professional association, or professional certifying organization – upload documents.

61. Has your privilege to possess, dispense, administer, or prescribe controlled substances or other prescription medications or devices ever been suspended, revoked, denied, restricted, or surrendered as the result of an investigation or action by any governmental entity at any time? If yes, provide the entity that acted on your privilege to prescribe, the nature of the limitation or action, the date of the action, and a description of the circumstances underlying the action in the following questions, and upload any relevant documentation you have regarding the action where indicated.

No

62. Entity that took action on prescribing privileges:

63. Action taken:

64. Date of action taken regarding prescribing privileges:

65. Circumstances underlying action on prescribing rights:

66. Action taken on prescribing privileges – upload documents.

67. Are you presently a defendant in a criminal proceeding?

No

68. Court:

69. City and state:

70. Charge:

71. Description:

72. Status:

73. Date:

74. Defendant in criminal proceeding - Upload Documents:

75. Do you currently prescribe, or have you ever prescribed, prescription medication or devices solely in response to communication by computer or other electronic means? This does not include: initial admission orders for newly hospitalized patients; prescribing for patients of a physician for whom you have taken call; prescribing for a patient examined by a licensed advanced practice registered nurse or physician assistant, or other practitioner with whom you have a supervisory or collaborative relationship; continuing medication on a short-term basis for a new patient prior to the new patient's first appointment; or emergency situations in which the life or health of the patient is in imminent danger. Nor would this include the use of an electronic medical record or other system for entering and transmitting prescriptions.

No

76. If you answered yes to the preceding question, provide a general description of any prescribing you do in response to electronic communications.

Renewal Part III

PART III

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

Any "yes" response to the questions below must be fully explained.

77. To your knowledge, are you currently the subject of a criminal investigation that has not yet resulted in charges against you? If yes, provide the jurisdiction, a description of the matter under investigation, and the date you became aware of the investigation in the following questions.



78. Jurisdiction:

79. Description of matter under Investigation:

80. Date you became aware of Investigation:

81. Upload any documents you may have relating to the matter under investigation:

82. To your knowledge, are you the subject of an investigation by any other licensing or certification board that has not yet resulted in charges as of the date of this application? If yes, provide the board involved, the date you became aware of the investigation, and a description of the matter under investigation in the following questions and upload relevant documents where indicated.



83. Licensing or certification board conducting investigation:

84. Date of event(s) under investigation:

85. Nature of event(s) under investigation:

86. Please upload any documents you have that are relevant to this matter.

MEDICAL DEFINITIONS

The following definitions are provided to assist you in answering the medical related questions:

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make and exercise reasoned medical judgements, 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 and 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 medical professional.

"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.

Medical condition, treatment, use of chemical or illegal substances:

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



88. If you answered yes to the preceding question please identify the impairment and explain how you address it in practice

89. Please upload any documents you have that are relevant to this matter.

90. 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?



91. If you answered yes to the preceding question please explain how you address it in order to practice with reasonable skill and safety.

92. Please upload any documents you have that are relevant to this matter.

93. Are you currently engaged in the illegal use of controlled substances?



94. In explaining a "Yes" answer to the previous question, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

95. Please upload any documents you have that are relevant to this matter.

96. Treating organization:

97. Address:

98. Telephone:

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

100. Dates of illness or dependency (from, to):

101. Dates of treatment (from, to):

102. Name of rehabilitation/professional assistance or monitoring program:

103. Address:

104. Telephone:

105. Contact person at Program:

Renewal Part IV

Statutory Profile Questions

In accordance with Vermont law, the Board of Medical Practice collects certain information from licensed or certified health care professionals and maintains it in a data repository that is made available to the public. 26 V.S.A. § 1368. The publicly-available data base is commonly referred to as the online profile. When licenses are issued to applicants, instructions are provided as to how to review and update the information provided for the online profile. Answering these questions is mandatory, except for certain optional questions. Those that are optional are clearly identified. Information collected for the statutory profiles may be considered by the Board in its review of the license application. Statutory profile information is displayed to the public for only ten years, but the questions are not time-limited and you must respond regarding your full history.

Applicants with other events or actions that must be reported (e.g., a criminal conviction) must provide documentation of each event. It is very important for the Board to receive copies of court papers, licensing authority decisions, or similar documentation, as noted below. The Board will not act on an application that lacks required documentation. **If any reportable event involves alcohol or drugs in any way, you must contact the Vermont Practitioner Health Program to arrange for an evaluation. The Board will not act on an application that is missing a required evaluation.** You may contact VPHP at (802) 223-0400. Information about VPHP is online at: <http://www.vtmd.org/health-professional-wellness-and-recovery-programs>.

106. **Criminal Convictions** [See 26 VSA § 1368(a)(1)] Have you been convicted of any crime? This includes both misdemeanors and felonies; it includes crimes such as driving under the influence (DUI), but not non-criminal traffic offenses such as speeding or parking tickets. For purposes of this question, "convicted" means that you pleaded guilty or were adjudged guilty by a court of competent jurisdiction: Matters expunged or annulled. A conviction or nolo contendere matter that was subsequently expunged or annulled under a law providing that the arrest, conviction, and sentence would thereafter be treated as if they never occurred, need not be disclosed.

No

107. **Criminal Convictions continued** [See 26 VSA § 1368(a)(1)] Provide information regarding each conviction as defined above. **In addition to entering the information here, you must submit copies of documents that show information about the crime(s) of which you were convicted and the sentence imposed, to include the police report, any ticket/citation/indictment/arrest record, and final disposition.**

Date of Conviction	Court of Conviction	City	State	Description
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108. **Nolo Contendere/Matters** [See 26 VSA § 1368(a)(2)]

Have you ever had a criminal involvement that resulted in a case resolved by a plea of "nolo contendere," or where after finding facts that would establish guilt the matter was continued by the court in lieu of a conviction?

No

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

Provide information regarding each criminal involvement resolved by a plea of "nolo contendere," or where after finding facts that would establish guilt the matter was continued by the court in lieu of a conviction.

Date of Charges	Court	City	State	Description of Charges
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110. **Vermont Board of Medical Practice Matters** [See 26 VSA § 1368(a)(3)]

Have you ever been served charges by, or been the subject of an order by the Vermont Board of Medical Practice or other Vermont professional licensing authority? (This includes stipulations, consent orders, or other voluntary resolutions that you accepted after being notified of an investigation, even if no charges were served.)

No

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

Provide information regarding each instance in which you were charged by, or were the subject of an order by the Vermont Board of Medical Practice or other Vermont professional licensing authority, including the findings, conclusions, orders, and final disposition of the matter by the courts, if applicable.

Date	Final Disposition Summary
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112. **Licensing Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]

Have you ever been charged by, or been the subject of an order by a professional licensing or certification authority in any other US state or territory, or Canadian territory or province? (This includes stipulations, consent orders, or other voluntary resolutions that you accepted after being notified of an investigation, even if no charges were served.)

No

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

Provide information regarding each incident in which you have been charged by or been the subject of an order by a professional licensing or certification authority in any other state, territory, or province. Provide documentation that shows the charges, findings, conclusions, and orders, plus final disposition by any court or appeal authority, if appealed.

Date of Disposition	Licensing Authority	City	State	Description of Disposition
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Restriction of Hospital Privileges [See 26 VSA § 1368(a)(5)]

114. Have you ever had hospital privileges revoked or involuntarily restricted for reasons related to competence or character?

No

115.

A. Revocation or Restriction of Hospital Privileges Information

Provide information about each instance in which hospital privileges were revoked or involuntarily restricted for reasons related to competence or character. Provide documentation that shows the date, basis for the action, the authority who took the action, and the action taken.

Date of Restriction	Hospital Name	State	Nature of Restriction	Reason for Restriction
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116. Have you ever, after having been notified of an investigation or peer review that was not yet resolved, or in lieu of or in settlement of a pending disciplinary case related to competence or character, done any of the following:

resigned medical staff membership or privileges;

not renewed medical staff membership or privileges; or, -

consented to a restriction of hospital privileges?

No

B. Resignation or Nonrenewal of Medical Staff Membership, or Restriction of Privileges Information

Provide information about each instance in which you resigned or did not renew medical staff membership, or you had hospital privileges restricted, after having been notified of an investigation or peer review that was not yet resolved, or in lieu of or in settlement of a pending disciplinary case related to competence or character? Provide documentation that shows the date, the hospital, the basis for and nature of the case, and the terms of settlement, if any.

Date	Hospital Name	State	Action	Nature of Action	In Lieu or In Settlement
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118. Medical Malpractice Court Judgments & Settlements Have you ever had a medical malpractice claim against you that is still pending or that resulted in any of the following:

- a court judgment against you; or

- an arbitration award or a settlement that you or another party paid on your behalf?

If you have any such cases, you must provide information as requested in the questions below. You must also complete a Medical Malpractice Case Information Form for each. The form is located [here](#) Download the form, fill it out completely, and upload it where indicated. A form must be completed and submitted for each case. You must also provide documentation for each case as explained on the form.

119. A. Judgments

Provide the information requested in the following table for each case in which there was a court judgment or arbitration award against you.

Date of Judgment	Number of Judgments
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120. B. Settlements

Provide the information requested in the following table for each case in which you were named as a defendant and in which a settlement was paid by you or on your behalf.

Date Of Settlement

121. C. Pending Cases

Provide the information requested in the following table for each case that is currently pending against you.

Date

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

Note: Providing the following Appointments and Teaching information 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.)

122. **A. Appointments** Please provide information about your appointments to medical school or professional school faculties.

School	City	State	Nature of Appointment	Year Started	Year Ended
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123. **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	Year Started	Year Ended
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124. **Publications** [See 26 VSA § 1368(a)(13)]

Note: Answering this question 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	Publication Date
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125. **Activities** [See 26 VSA § 1368(a)(14)]

Note: Answering this question 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.

Activity or Award

126. Provide information about each current and planned practice location, wherever located. Indicate which is planned to be your primary Vermont practice location.

Practice Name	City	State	Primary Practice	Languages	Accepts Medicaid?	Accepts New Medicaid Patients?
98point6	Seattle	Washington	Yes		No	No

Statement of Good Standing

127.

**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 either:

A. This does not apply to me because I don't have any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense, or

B. 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.

Yes

128. Date:

11/05/2020

Child Support, Taxes

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT AND TAXES

You must answer these questions.

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)

129. You must select 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.

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)

130. You must select 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.)

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.

131. Social Security Number:

██████████

132. Date of Birth:

██████████

133. 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.

Yes

134. Date:

11/05/2020

Continuing Medical Education Requirements

Each applicant for renewal must certify that he or she meets the requirements for CME as indicated by one of the statements below, a – f. Note that for purposes of this certification, completion of an activity includes taking the steps necessary to receive credit and obtain documentation of completion. If you cannot certify that you are eligible to renew your license because one of the statements applies to you, then you must contact the Board of Medical Practice to discuss your renewal application. You are not required to submit documentation of your CME activities with your renewal application, but licensees are subject to audit and may be asked to submit such documentation during the next two licensing cycles (for this renewal, through November 30, 2024).

The Rules for Continuing Medical Education are found in the Board Rules beginning at page 15 online at: **a) I do not have to complete CME for this renewal because I was licensed as an MD in Vermont for the first time on or after December 1, 2019.**

b) I was licensed as an MD for the first time in Vermont between December 1, 2018 and November 30, 2019. Accordingly, my requirement is to have completed at least 10 hours of qualifying AMA PRA Category 1 Credit CME and at least one of those hours was on one or more of the following subjects: hospice, palliative care, and/or pain management services. In addition, if I hold or have applied for a DEA number to prescribe controlled substances, at least two of the qualifying

hours I completed were on the subject of safe and effective prescribing of controlled substances. I have completed the applicable requirements.

c) I have completed at least 15 hours of qualifying AMA PRA Category 1 Credit CME and at least one of those hours was on one or more of the following subjects: hospice, palliative care, and/or pain management services. In addition, if I hold or have applied for a DEA number to prescribe controlled substances, at least two of the qualifying hours I completed were on the subject of safe and effective prescribing of controlled substances.

d) I am a member of the armed forces of the United States and I was subject to a mobilization and/or deployment (or multiple mobilizations and/or deployments totaling) one year or more. Accordingly, I am not required to certify that I completed CME for this renewal.

e) I am a member of the armed forces of the United States and during the period from December 1, 2018 to November 30, 2020 I was subject to a mobilization and/or deployment (or multiple mobilizations and/or deployments totaling) less than one year. Accordingly, my requirement is to have completed at least 10 hours of qualifying AMA PRA Category 1 Credit CME and at least one of those hours was on one or more of the following subjects: hospice, palliative care, and/or pain management services. In addition, if I hold or have applied for a DEA number to prescribe controlled substances, at least two of the qualifying hours I completed were on the subject of safe and effective prescribing of controlled substances. I have completed the applicable requirements.

f) I have not completed the required CME for renewal, but I have submitted a make-up plan that I have signed and that was approved by the Executive Director of the Board.

135. I hereby certify that I have satisfied the Vermont Board of Medical Practice requirements for CME as indicated in the above statement. Select the one that best applies.

C

MD Workforce Survey

Since 1999, the State of Vermont has been conducting a census of some professions every two years as part of relicensing. This has allowed us to monitor changes in Vermont's health care workforce. In 2012, the Legislature enacted a law to make work force data collection mandatory for all health care professions at license renewal as a necessary part of health care reform and planning for our health care future. We would like to thank you for your participation in this census.

Since the survey has become a mandatory step of the process to renew a physician license, several licensees have certified that they completed the survey, when they had not. Please certify that you have completed the survey only once you have done so. If you encounter difficulty completing it, please contact the Public Health Statistics office as indicated on the survey site. Each licensee must complete the survey, and if it is not complete the renewal applicant will be contacted. In addition, the names of those who incorrectly certify that they have completed the survey will be provided to the Board of Medical Practice for investigation of possible unprofessional conduct. Please complete the survey. The State of Vermont needs a complete data set to establish reliable information about the healthcare workforce.

You must complete the workforce survey before you may complete your application to renew your license. The mandatory workforce survey is accessed by clicking [here](#)

136. I hereby certify that I have completed the workforce Census per the above instructions

Yes

Renewal Payment

137. You must choose one of the following payment options to complete your application. Note: Your application will NOT be processed by the Medical Board until payment is received. If you are a commissioned officer on active duty in the armed forces, you must submit a copy of your current active duty orders.

Credit Card (can only be done at this time)

Review