Vermont Department of Health
Board of Medical Practice

Agency of Human Services

June 15, 2005

Sarah Rice MD
[redacted]

Re: Vermont Medical Licensure - **042-0010987**

Dear Dr. Rice:

Congratulations on receiving a license to practice medicine in Vermont. On June 15, 2005, the Vermont Board of Medical Practice granted you a Vermont medical license. Please note your license number above. Enclosed please find your physician license and information relevant to practice in Vermont. A wall certificate is being processed and will be sent to you under separate cover.

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

Tracy Hayes
Administrative Assistant

Enclosures

108 Cherry Street • PO Box 70 • Burlington, VT 05402-0070 **TEL** 802- 657-4220 or 800-745-7371
FAX 802- 657-4227

State of Vermont
Board of Medical Practice

THIS IS TO CERTIFY

That ***Sarah Arnott Rice MD***

a graduate of The University of Washington, 2000

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

Chair: Edward Patrick Smith JR, DPM

Secretary: Margaret F. Martin

License Number 42-0010987

Burlington
Date: June 15, 2005
Received and duly recorded.
Vermont Department of Health

Vermont Department of Health
Board of Medical Practice

Agency of Human Services

May 31, 2005

Sarah Rice MD
[redacted]

Dear Dr. Rice:

Your application for medical licensure appears to be complete. It now becomes your responsibility to contact the Board member listed below to arrange for your personal interview:

John J Murray, M.D.
[redacted]

You must complete your interview within six months from the date of this letter or your application will be considered stale. This means that you will have to update the following: License verifications from other states; three letters of recommendation, National Practitioners Data Bank Self Query, and the AMA Profile.

The full Board will act upon your request for licensure at the next scheduled Board meeting following your interview.

Should you have questions or concerns, please feel free to contact me at 802-657-4223.

Sincerely,

Tracy

Tracy Hayes
Board of Medical Practice

108 Cherry Street • PO Box 70 • Burlington, VT 05402-0070 **TEL** 802- 657-4220 or 800-745-7371
FAX 802- 657-4227

Vermont Department of Health
Board of Medical Practice

Agency of Human Services

5/31/2005

John Murray, MD
[redacted]

Dear Dr. Murray:

The application for medical licensure for **Sarah Rice, MD** appears complete, and is enclosed for your review. The applicant will be calling you to schedule a personal interview. Following the interview, you may present the application at the first, regularly scheduled Board meeting.

Should you have any questions or concerns, please let me know. (802) 657-4223.

Sincerely,

Tracy Hayes
Administrative Assistant
Board of Medical Practice

Enclosures

108 Cherry Street • PO Box 70 • Burlington, VT 05402-0070 **TEL** 802- 657-4220 or 800-745-7371
FAX 802- 657-4227

5/24/05

Tracy,

Here is another photo. Please let me know if it is not ok. I am moving to Vermont this Thursday 5/26. My new address will be:

[redacted]

Thanks!

SARAH RICE MD

Burl

Medical Doctor Application Checklist
For Office Use Only
STATE OF VERMONT - BOARD OF MEDICAL PRACTICE

Name of Applicant: Sarah Beth Rice
Address: [redacted]

Telephone [redacted]

Date Application Received: 4/22/05

____**US Graduate** ____**Canadian Graduate** ____**International Graduate**
(Unless noted, a copy of original, and English translation if applicable, is requiredto be submitted):

1) X **FEE of $450.00**

2) X **COMPLETED APPLICATION** for License to Practice Medicine in Vermont.

X **Photograph Applicant's signature required on photograph.**
X **Tax & Child Support Statement Applicant's signature required.**
X **Form B: Release Applicant's signature required.**

*3) X **BIRTH CERTIFICATE - Notarized**
Date of Birth: [redacted] Place of Birth: _____

*4) X **MEDICAL SCHOOL DIPLOMA – Notarized**
Univ of Washington Date: 6/9/00

*5) X **MEDICAL EDUCATION CERTIFICATE- Direct Verification**

6) X **MEDICAL LICENSURE CERTIFICATE - Direct Verification**
☐ **All in good standing**

X WA _____ ___ _____
___ _____ ___ _____
___ _____ ___ _____

*7) X **EXAMINATION SCORES: Direct Verification of Examination Scores:**

X **USMLE**** ____ **FLEX** ____ **National Boards** ____ **State Exam**

___Number of times applicant has taken USMLE Step 3 (can be no more than 3 times).
___Number of years applicant has taken to complete (can be no more than 7 times)

8) X **AMERICAN SPECIALTY BOARD CERTIFICATE, if applicable - Notarized**
Family Practice (BC)

*9) X **POSTGRADUATE TRAINING** from an ACGME approved residency program - **Direct Verification**. VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION must be completed by Program Director.

X Family Medicine Spokane DATES 2003 ACGME _____

_____ DATES _____ ACGME _____

_____ DATES _____ ACGME _____

10) X **Three (3) COMPLETED REFERENCE FORMS** mailed directly to the Board by the Chief of Service and two other active physician staff members at the hospital where the applicant has a current or recent appointment. Program Director should be substituted for Chief of Service for applicants who are applying for license while still in residency training or have completed a residency within the last year.

X #1 Chief of Service Gary Newkirk

or ____ Program Director _____

X #2 Active Physician Staff Member Elizabeth Bianchi

X #3 Active Physician Staff Member Erika Bliss

11) X **American Medical Association Profile Form.**

☐ Verify information provided on application

*12) N/A **ECFMG Certificate, if International Graduate.** ____ **Verification of Fifth Pathway**

☐ Passed/Approved

13) X **National Practitioners Data Bank self-query: Applicant sends the original, unaltered response to the Board.**

☐ Has applicant included everything on the application

14) N/A **FORM A if applicant answered Yes in Section III—Refer to licensing Committee**

15) ____ **FEDERATION CHECK**

☐ Check for board actions

* **NOTE**: FCVS Acceptance - The Board accepts certain documents noted by asterisks (*) above.

pd $450 6

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

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

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

Instructions

- ***Please enclose a check in the amount of $450 payable to the Vermont Department of Health.***
- ***Please print legibly or type your answers. Please type or print in block letters, one letter (or digit) in each box.***
- ***Answer all questions completely.***
- ***Use the enclosed Form A to provide explanations to "yes" answers in Parts III and IV.***
- ***Please be sure to write your name on each attachment.***
- ***Please provide complete copies of all documentation related to questions 30 through 35.***
- ***Please be sure to complete the Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions.***
- ***Make a copy of the completed form and all attachments for your own records.***
- ***Do not delegate this important task to an employee. False statements on this form are grounds for unprofessional conduct.***

RECEIVED
APR 22 2005
VT BOARD OF MEDICINE

Part I - Identity Questions

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

First name: SARAH

Middle name: ARNOTT

Last name: RICE

Extension:

2. Have you ever legally changed your name? ☒ Yes ☐ No

I changed my name to SARAH RICE HENRY briefly & then changed it back after I was divorced to: SARAH ARNOTT RICE

If yes, enclose a certified copy of the legal document stating the change.

*Name as it should appear on your license: SARAH ARNOTT RICE

Other name(s), if any under which you were licensed elsewhere: never licensed under any other name

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

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

Care of: SARAH A. RICE

Street: [redacted]

RICE, SARAH

Town/City: [redacted]

State: [redacted]

Zip Code: [redacted] -

5. Your electronic addresses:

Home telephone (optional): [redacted] example: 802-555-1212

Work telephone: [redacted]

E-mail (optional): mciachnscyahoo.com

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

7. Have you ever held a Vermont Limited Temporary License: ☐ **Yes** ☒ **No**
If yes, License Number _____

8. Do you hold, or have you ever held, a medical license in any other state? ☒ **Yes** ☐ **No**

If yes, complete the section below:

State	License Number	Date Issued	Status (Active, inactive, other)
WA	MD00041649	09/11/2002	ACTIVE

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

Part II – Education, Training, Practice and Examinations

9. Premedical Education

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

Name and location of institution	Degree	From	To
U.C. BERKELEY	BA HISTORY		1991

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

10. Medical Professional Schools – See enclosed Certificate of Medical Education
Please provide the names of medical professional schools you attended and the dates of attendance.
Note: This information should be provided in the Statutory Profiles Section (Part V #36)

RICE, SARAH

11. Graduate Medical Education
Please provide the names of graduate medical schools you attended and the dates of attendance.
Note: This information should be provided in the Statutory Profiles Section (Part V #37)

12. Examinations
A. USMLE or FLEX Examination
Have you ever taken the USMLE or FLEX examination? X Yes _____ No
If yes, have a Certified Copy of your results forwarded to this office by the Federation of State Medical Board.

B. National Boards
Have you ever taken the National Boards? X Yes _____ No
If yes, have a Certified Copy of your results forwarded to this office by the National Board of Medical Examiners.

C. State Examination -
Have you ever taken a State Medical Board Examination? ____ Yes X No
If yes, make sure that the scores are included on the Certificate of Medical Licensure to be sent to that Board (see enclosed Certificate of Medical Licensure).

13. International Medical Graduates
A. ECFMG Standard Certificate Number: _____ Date issued: _____
B. Direct verification of your ECFMG Certificate must accompany this application. (See enclosed request form)
C. Are you a graduate of a fifth pathway program: ____ Yes _____ No
If yes, direct verification of your fifth pathway certificate must accompany this application.

14. Practice
Do you have hospital privileges? ____ Yes X No
List all hospitals where you have, or previously have had, staff privileges. Include name, address, and dates.

Name	Address	From/To	Specialty/Subspecialty

Part III - Licensure and Practice Questions

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

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

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

17. Have you ever voluntarily surrendered or resigned a license to practice medicine or any other healing art in lieu of disciplinary action?

☐ Yes ☒ No

18. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
☐ Yes ☒ No

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

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

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

22. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?
☐ Yes ☒ No

23. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?
☐ Yes ☒ No

24. Are you presently a defendant in a criminal proceeding?
☐ Yes ☒ No

Part IV - Confidential Section

Part III is exempt from public disclosure

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

25. To your knowledge, are you the subject of an investigation by any other licensing board as of the date of this application?

[redacted]

26. To your knowledge, are you presently the subject of criminal investigation?

[redacted]

MEDICAL QUESTIONS

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

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

[redacted]

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example,

RICE, SARAH

you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

28. 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?

[redacted]

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

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

[redacted]

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

IMPORTANT

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

DEFINITIONS

In answering the questions above, please use these definitions:

"Ability to practice medicine" - This term includes:

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

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

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

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

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the

RICE, SARAH

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.

Part V - Statutory Profile Questions

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

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

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

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

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

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

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

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

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

RICE, SARAH

				☐ Nolo Contendere ☐ Matter Continued
				☐ Nolo Contendere ☐ Matter Continued

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

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

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

N/A

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

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

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

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

N/A

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

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

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

A. **Revocation/Involuntary Restrictions**

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

N/A

RICE, SARAH

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

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

B. Other Restrictions N/A

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

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

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

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

A. Judgments [redacted]

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you. **Please complete Form A and provide copies of papers fully documenting these matters.**

[redacted]

RICE, SARAH

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

B. Settlements

Please provide a description of all settlements of medical malpractice claims against you. **Please complete Form A and provide copies of papers fully documenting these matters.**

[redacted]

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

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

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

School	City	State		Year of Graduation			
UNIVERSITY OF WASHINGTON,	SEATTLE	W	A	2	0	0	0

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

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

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

School/Institution	Specialty	City	State		Year of Graduation			
FAMILY MEDICINE SPOKANE	FAMILY MEDICINE	~~Spokane~~ SPOKANE	W	A	2	0	0	3

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

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

RICE, SARAH

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

Specialty Code	Specialty Name (if code unknown)	Board Certified	Name of Board	Year Certified	Year Recertified
0 6 0 1		☒ yes ☐ no	American Board of Family Medicine	2003	
		☐ yes ☐ no			
		☐ yes ☐ no			

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

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

M	M	Y	Y	Y	Y
0	7	2	0	0	3

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

List all hospitals where you currently have hospital staff privileges:

Name	City	State		Year Started			
NONE							

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

41. **Appointments/Teaching** [See 26 VSA § 1368(a)(12)] Note: Answering #35 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

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

School	City	State	Nature of Appointment	From (year)	To (year)
NONE					

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

B. Teaching

RICE, SARAH

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

School/Institution	City	State	Nature of Teaching	From (year)	To (year)
None					

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

42. **Publications** [See 26 VSA § 1368(a)(13)] Note: Answering #36 is optional. By answering, you are granting permission to have this information posted on the web.

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

Title	Publication	Year
NONE		

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

43. **Activities** [See 26 VSA § 1368(a)(14)] Note: Answering #37 is optional. By answering, you are granting permission to have this information posted on the web.

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

Activities or Awards

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

- End of Statutory Profile Questions -

RICE, SARAH

44. **Interview**

* we are moving to Burlington June 1, 2005 - I'm currently pregnant & due April 2005 and therefore cannot come to Vermont sooner.

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

BURLINGTON

B. When are you scheduled to begin work in Vermont? ? 7 or 8/05

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

SEATTLE, WA

Part VI - Ph

PLEASE PRO
Attach a recen
shoulders). P
photograph.

Part VII - S

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

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

Date: 2/20/05 _____

Applicant's Signature

Return completed application to:

VERMONT DEPARTMENT OF HEALTH
BOARD OF MEDICA PRACTICE
108 Cherry Street, P0 Box 70
Burlington VT 05402-0070

RICE, SARAH

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

You must answer questions 1, 2, and 3.

Regarding Child Support

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

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

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

or

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

Regarding Taxes

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

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

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

or

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

Regarding Unemployment Compensation Contributions

RICE, SARAH

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

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

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

or

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

or

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

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

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

STATEMENT OF APPLICANT

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

Signature of Applicant _____ Date 2/20/09

RICE, SARAH

FORM B

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

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

TO WHOM IT MAY CONCERN:

1) I, SARAH ARNOTT RICE, HEREBY AUTHORIZE YOU to furnish to the
(Name of Applicant)

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

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

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

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

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

Signature: _____

Date: 3/20/05

Print or Type Name: SARAH ARNOTT RICE

Address: [redacted]

City, State, Zip Code: [redacted]

Telephone Number: ([redacted]

Subscribed and sworn to before me, this 1st day of March, 2005.

_____
Notary Public

Affix Seal

My License Expires: Aug. 25 2007

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

Notary Public
State of Washington
SHADWICK CLAY NEWKIRK
My Appointment Expires Aug 25, 2007

COPY
ORIGINAL FILED
AUG 19 2002
SPOKANE COUNTY DISTRICT COURT

CERTIFIED TO BE A TRUE AND
CORRECT COPY OF THE DOCUMENT PRESENTED
BY: Brad Mehlig
Sr. Personal Financial Rep
WASHINGTON MUTUAL BANK

IN THE DISTRICT COURT OF SPOKANE COUNTY WASHINGTON

In the matter of the Petition of Sarah Rice Henry D.O.B. [redacted]	NO. 221867 **ORDER CHANGING NAME**

The Petition of the above-named person for an order changing his/her present name, came regularly to be heard this date; the court having heard the evidence and it appearing to the satisfaction of the court that the allegations of the Petition for Change of Name are true; now therefore, it is hereby

ORDERED, ADJUDGED AND DECREED that the name of Sarah Rice Henry **be changed to** Sarah Arnott Rice

DONE IN OPEN COURT this 19 **day of** Aug, 2002

SEAL OF THE SPOKANE COUNTY DISTRICT COURT STATE OF WASHINGTON

JUDGE/COURT COMMISSIONER
BROADWAY CENTRE BUILDING
721 N. JEFFERSON
SPOKANE, WA 99260

Presented by:
Sarah Rice Henry
Pro Se
17 West 31st
Street Address
Spokane, WA 99203
City, State, Zip

IN THE DISTRICT COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY AND DISTRICT OF SPOKANE

THE FOREGOING INSTRUMENT IS A CORRECT COPY OF THE ORIGINAL AS THE SAME APPEARS OF RECORD.

DATED THIS 19 DAY OF Aug 20 02

BY _____
CLERK

The University of Washington

To all to whom these Letters shall come, Greeting:

The Regents of the University on recommendation of the Faculty of the School of Medicine and by virtue of the Authority vested in Them by Law have this day admitted

Sarah Arnott Rice

to the degree of

Doctor of Medicine

and have granted all the Rights, Privileges and Honors thereto pertaining

Given at Seattle, in the State of Washington, this ninth day of June, two thousand and of the University the one hundred and fortieth.

Richard L. McCormick
President of the University

William N. Foster
President of the Board of Regents

Paul G. Ramsey
Dean, School of Medicine

I certify this to be a true and exact copy of the original.
Deanna L. McKee
Notary Public
State of Washington
Commission expires
03/13/2005

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

RECEIVED
MAR 0 3 2005
REGISTRATION SCHEDULING

CERTIFICATE OF MEDICAL EDUCATION

To be completed by an officer of your School of Medicine

I hereby certify that SARAH ARNOTT RICE (Name) was admitted to the

University of Washington School of Medicine

in Seattle, Washington (City and State) on 09/23/1996 (Date)

MAR 8 2005

and completed all requirements for graduation on 06/09/2000 (Date).

A M.D. (Specify certificate/diploma/degree) was granted on June 9, 2000 (Date)

(AFFIX SEAL)

Date: 03/03/2005

Signed: Trudy L. Furberry
(Authorized Officer of the School)

Trudy L. Furberry, Certifying Officer

Washington State Department of Health

Health Professions Quality Assurance
Credential Look Up Results
Data as of 03/10/2005 2:45:44 PM

Disclaimer

The Washington Department of Health presents this information as a service to the public. The disciplinary information displayed contains data gathered since July 1998. The absence or presence of information in this system does not imply any recommendation, endorsement, or guarantee of competence of any health care professional, nor does the mere presence of such information imply a practitioner is not competent or qualified.

This site is a Primary Source for Verification of Credentials.

CURRENT PRACTITIONER INFORMATION

Name:	RICE, SARAH A
Year of Birth:	[redacted]
Credential Number:	MD00041649
Credential Type:	Physician And Surgeon
Current Credential Status:	Active
First Credential Date:	09/11/2002
Expiration Date:	01/03/2006
Last Renewal Date:	12/30/2003
Action Taken:	No

RECEIVED
MAR 16 2005

Betty Ellert

OTHER CREDENTIAL(s) HELD

Credential Number	Credential Type	Credential Status	Action Taken	Practice Conditions
NA00073498	Nursing Assistant - Registered	Expired	No	No

Search again, using new criteria?

Back Forward Print

American Board of Family Practice

Sarah Arnott Rice, M.D.

having met all its requirements

is hereby certified to be a

Diplomate

of this Board for the period

2003-2010

Executive Director and Secretary

President

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

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, PO Box 619850, Dallas, TX 75261-9850 -- Telephone (817) 868-4041

Date: 04/26/2005

Recipient:

Vermont Board of Medical Practice
ATTN: Gloria Hurd; Exec Director
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070

APR 29 2005

Examinee ID#: 5-046-299-3
Examinee: Rice, Sarah Arnott
Alt Name(s): Henry, Sarah Rice
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. Where numeric scores are reported, there are two scales used and the recommended minimum passing score ("MP") on each scale is shown in parentheses.

USMLE STEP 1

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	06/09/1998	Pass	192	179	79	75	

USMLE STEP 2

Clinical Knowledge (CK)

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
	09/21/1999	Pass	179	170	77	75	

USMLE STEP 3

			Three-Digit Score		Two-Digit Score		
	Test Date	Pass/Fail	Total	MP	Total	MP	Comments
WASHINGTON	11/26/2001	Pass	215	182	87	75	

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

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

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

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

To be completed by the Training Program Director:

Name of Institution: FAMILY MEDICINE SPOKANE

Address: Fifth & Bramc Medical Centre
104 West 5th Suite 200 W
Spokane, WA 99204

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

I hereby certify that SARAH A. RICE (Name) was enrolled in the

Family Medicine Residency
Program Type (residency, fellowship)

_____
Department (e.g. Radiology, Internal Medicine)

at this institution from 07 / 01 / 2001 (Month / Day / Year) to

06 / 30 / 2003.
Month / Day / Year

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

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

06 / 30 / 2003.
Month / Day / Year

(AFFIX SEAL)

Date: 4/12/2005

Signed: _____
(Official of the Sponsoring Institution)

Print Name: Gary R. Nowick, MD

Title: Program Director

I do outpatient family practice * have no current hospital privileges, therefore my refs come from the outpatient setting.

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

LIST OF THREE REFERENCES

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

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

Names, addresses and telephone numbers of three references:

1) Reference #1 - Chief of Service (See Program Director Note * above): GARY NEWFIRK MD

Address: Fifth & Browns Medical Center
104 West 5th Suite 200W

City, State, Zip Code: Spokane, WA 99204-4839

Telephone: (509) 624 2313

How long and in what capacity has this individual known you? 2001 - present

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

Name: ELIZABETH BIANCHI MD

Address: 4708 Schafer Rd

City, State, Zip Code: Spokane, WA 99202

Telephone: (509) 869 8951

How long and in what capacity has this individual known you? 2003 - present

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

Name: ERIKA BLISS MD

Address: 6726 35th Place South

City, State, Zip Code: Seattle, WA 98118

Telephone: (206) 299-1900

How long and in what capacity has this individual known you? 2000 - present

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

Chief of Service Form
Return Directly to Board

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

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

Name of Applicant: SARAH A. RICE

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

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

Dr. Sarah A. Rice was at Family Medicine Spokane from 07/01/2002 to 06/30/2003. During that time, he/~~she~~ was (List status in the Institution): Resident 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.

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

Chief of Service Form
Continued

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

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

Name of Applicant: Sarah A. Rice

How long have you known the applicant and in what capacity? _____

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? X Yes ___ No

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

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

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

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

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

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

Does the applicant call upon consults when needed? X Yes ___ No

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

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

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

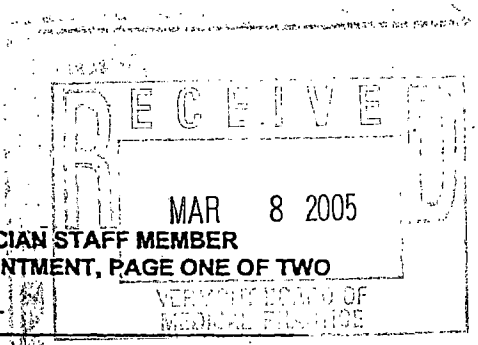
I recommend Sara Rice MD for licensure in Vermont.
Name of Physician

Signed: Gary R. Neukirk Date: April 12, 2005

Print or Type Name and Title: Gary R. Neukirk M.D. Director.

Reference Form #2
Return Directly to Board

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



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

Name of Applicant: SARAH A. RICE

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

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

Dr. Sara Rice was at Planned Parenthood from ~1/03 to 3/05. During that time, he/she was

(List status in the Institution): Staff 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.

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

Reference Form #2
Continued

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

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

Name of Applicant: Sara Rice

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

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

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

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

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

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

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

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

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

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

The above report is based on:

- X Close personal observation
- ____ General impression
- ____ A composite of faculty/staff evaluations
- ____ Other - Specify: ____

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

I recommend Sara Rice for licensure in Vermont.
Name of Physician

Signed: Eli Bianchi MD Date: 3/4/05

Print or Type Name and Title: Elizabeth Bianchi MD

Reference Form #3
Return Directly to Board

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

APR 1 2005

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

Name of Applicant: SARAH ARNOTT RICE

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

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

Dr. Sarah Rice was at Carolyn Downs Family Med Ctr.
from October 2004 to February 2005. During that time, he/she was
(List status in the Institution): a locums 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.

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

Reference Form #3
Continued

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

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

Name of Applicant: Sarah Rice

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

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

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

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

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

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

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

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

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

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

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

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

I recommend Sarah Rice for licensure in Vermont.
Name of Physician

Signed: [signature] Date: 3/26/05

Print or Type Name and Title: Erika Bliss, MD
Clinical Site Director