



Affidavit and Authorization for Release of Information

This form should be sent to the state board you are applying to, NOT to FSMB.

Applicant:

Securely tape or glue a recent (less than 6 month old) front-view 2" x 2" passport-type color photo of yourself in the square below.

Sign this form with attached photo in the presence of a notary public.

Send the notarized form to the board you are applying to for licensure.

DO NOT SEND THIS FORM TO FSMB.

Doing so will cause a delay with your state board application.

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.

Applicant Photograph

Please see the instructions above.

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

Applicant's printed last name

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

Date of signature (must correspond to date of notarization)

Notary

State of _____, County of _____

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 _____ day of _____, 20_____.

Notary Public Signature: _____

(NOTARY PUBLIC SEAL)

My Notary Commission Expires: _____

EMPLOYMENT CONTRACT

I, _____, an applicant for
(Applicant's Name)

Licensure as a Physician Assistant, will be employed by

(Employer's Name)

for the period beginning _____
(Month/Day/Year)

Signature of Physician Assistant (Date)

Signature of Supervising Physician (Date)

Print Name of Physician _____

(Must have employment contract for each office)

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VT 05401
(802) 657-4223

PRIMARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

Name of Supervisor _____
(Last) (First) (Middle)

Address where PA will be supervised:

(Office Name)

(Street)

(City/State) (Zip Code) (Telephone Number)

Supervisors Vermont License #: _____

| Hospital(s) where you have privileges: | Hospital(s) Location | Specialty |
|--|----------------------|-----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

What arrangements have you made for supervision when you are not available or out of town:

CERTIFICATE OF SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of _____, P.A. while under my supervision. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice. I further certify that notice will be posted that a physician assistant is used, in accordance with 26 VSA, Chapter 31, Section 1741.

I further certify that I have read the statutes and Board rules governing physician assistants.

Signature of Supervising Physician: _____ Date: _____

Signature of PA: _____ Date: _____

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA.
PA's DEA Number _____

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VT 05401
(802) 657-4223

SECONDARY SUPERVISING PHYSICIAN APPLICATION

Please print. Incomplete applications will be returned. Attach additional sheets as needed.

Name of Supervisor: _____
(Last) (First) (Middle)

Address where PA will be supervised:

(Office Name)

(Street)

(City/State) (Zip Code) (Telephone Number)

Supervisors Vermont License #: _____

| Hospital(s) where you have privileges: | Hospital(s) Location | Specialty |
|--|----------------------|-----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

List all physician's assistants names and addresses you currently supervise:

CERTIFICATE OF SECONDARY SUPERVISING PHYSICIAN

I hereby certify that, in accordance with 26 VSA, Chapter 31, I shall be legally responsible for all medical activities of _____, P.A. only when the primary supervising physician is unavailable and only when consulted by the aforesaid Physician Assistant. I further certify that the protocol outlining the scope of practice, attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 31, Section 1741, the use of a physician assistant has been posted.

I further certify that I have read the statutes and Board rules governing physician assistants.

Signature of Secondary Supervising Physician: _____

Date: _____

"Delegation agreement" means a detailed description of the duties and scope of practice delegated by a primary supervising physician to a physician assistant (PA) that is signed by both the physician assistant and the supervising physicians.

In order to practice, a licensed physician assistant shall have completed a delegation agreement as described in section 1735a of this title with a Vermont licensed physician signed by both the physician assistant and the supervising physician or physicians. The original shall be filed with the board and copies shall be kept on file at each of the physician assistant's practice sites. All applicants and licensees shall demonstrate that the requirements for licensure are met.

A delegation agreement should cover at least the following items, and must be submitted for each location the PA will be working.

- a) Narrative: a brief description of the practice setting, the types of patients and patient encounters common to this practice site and a general overview of the role of the PA in that practice
- b) Supervision: A detailed explanation of the mechanisms for on-site and off-site physician supervision and communication, back-up and secondary supervising physician utilization. Included here should be a description of the method of transport and back-up procedures for immediate care and transport of patient who are in need of emergency care when the supervising physician is not on premises. This explanation should include issues such as ongoing review of the physician assistants activities, chart reviews (quantity and time frame), co-signing of patient charts, and utilization of the services of non-supervising physicians and consultants.
- c) Site(s) of practice: A description of any and all practice sites (i.e. office, clinic, hospital outpatient, hospital inpatient, industrial sites, schools, etc.)
- d) Tasks/Duties: A list of the PA's tasks and duties. This list should express a sense of involvement in the level of medical care in that practice. The supervising physician may only delegate those tasks for which the PA is qualified by education, training and experience to perform. Notwithstanding the above, the PA should initiate emergency care when required while accessing back-up assistance. At no time should a particular task assigned to the PA fall outside of the scope of practice of the supervising physician.
- e) Prescribing: What schedules the PA may prescribe. PA's DEA Number
- f) Signature and date from both the Primary supervising physician and the PA.

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401
(802) 657- 4223

CERTIFICATE OF PHYSICIAN ASSISTANT EDUCATION

I hereby certify that, _____ was admitted to the
(Name)

_____ Physician Assistant

Program in _____ on _____
(City and State) (Date)

and completed all requirements for graduation on _____
(Date)

A _____ was granted on _____
(Specify certificate/diploma/degree) (Date)

Is this program CAHEA or successor agency approved? _____ Yes _____ No

(AFFIX SEAL)

Date: _____

Signed: _____
(Authorized Officer of the School)

TO PROGRAM: Return to above address

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4223

VERIFICATION OF PHYSICIAN ASSISTANT LICENSURE OR CERTIFICATION

This section must be completed by the regulatory authority in the states in which **you now hold or have ever held** a license or certification to practice as a physician's assistant.

I, _____ Secretary of the _____

State Board of _____, certify that

_____ was granted Certificate Number _____

to practice as a physician's assistant in the State of _____

on the _____ day of _____ 19 _____

and that said certificate has never been revoked, suspended or conditioned in any way, or the licensee has never been disciplined by the Board in any way.

NOTE: If licensed by written examination the secretary should further certify:

I further certify that the aforesaid _____ in his/her written

Examination before this Board, obtained a general average of _____ percent in the

Following branches:

(The subjects of the examination and rating of each must be stated in full.)

(AFFIX SEAL) _____
(Secretary/Director)

(Date)

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220

Name of applicant: _____

The physician assistant named above has applied to the Vermont Board of Medical Practice for a certification to practice as a physician assistant 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.

Name _____ was at _____

From _____ to _____. During that time, he/she

Was (List status in the institution): _____

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 to be expected in a PA: | _____ | 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 skills in the tasks delegated: | _____ | Poor | _____ | Fair | _____ | Average | _____ | Above Average |
| Cooperativeness ability to work with others: | _____ | Poor | _____ | Fair | _____ | Average | _____ | Above Average |
| Willingness to accept directions and limitations in role: | _____ | Poor | _____ | Fair | _____ | Average | _____ | Above Average |
| History & physical exam: | _____ | Poor | _____ | Fair | _____ | Average | _____ | Above Average |
| Record keeping: | _____ | Poor | _____ | Fair | _____ | Average | _____ | Above Average |
| P.A.-Patient relationship: | _____ | Poor | _____ | Fair | _____ | Average | _____ | Above Average |
| Track record in adhering to scope of practice: | _____ | Poor | _____ | Fair | _____ | Average | _____ | Above Average |
| Ability to communicate in reading, writing and speaking the English language: | _____ | Poor | _____ | Fair | _____ | Average | _____ | Above Average |

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY
PAGE TWO OF TWO

Name of applicant: _____

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? 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 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 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 physician assistant, he/she was competent to practice as a physician assistant and he/she was not the subject of any disciplinary action.

I recommend _____ for licensure in Vermont.

Signed: _____ Date: _____

Print or Type Name and Title: _____

**STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220**

Name of applicant: _____

The physician assistant named above has applied to the Vermont Board of Medical Practice for a certification to practice as a physician assistant 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.

Name _____ was at _____

From _____ to _____. During that time, he/she

Was (List status in the institution): _____

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 to be expected in a PA: | _____ | 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 skills in the tasks delegated: | _____ | Poor | _____ | Fair | _____ | Average | _____ | Above Average |
| Cooperativeness ability to work with others: | _____ | Poor | _____ | Fair | _____ | Average | _____ | Above Average |
| Willingness to accept directions and limitations in role: | _____ | Poor | _____ | Fair | _____ | Average | _____ | Above Average |
| History & physical exam: | _____ | Poor | _____ | Fair | _____ | Average | _____ | Above Average |
| Record keeping: | _____ | Poor | _____ | Fair | _____ | Average | _____ | Above Average |
| P.A.-Patient relationship: | _____ | Poor | _____ | Fair | _____ | Average | _____ | Above Average |
| Track record in adhering to scope of practice: | _____ | Poor | _____ | Fair | _____ | Average | _____ | Above Average |
| Ability to communicate in reading, writing and speaking the English language: | _____ | Poor | _____ | Fair | _____ | Average | _____ | Above Average |

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY
PAGE TWO OF TWO

Name of applicant: _____

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? 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 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 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 physician assistant, he/she was competent to practice as a physician assistant and he/she was not the subject of any disciplinary action.

I recommend _____ for licensure in Vermont.

Signed: _____ Date: _____

Print or Type Name and Title: _____