

**Affidavit and Authorization for Release of Information:** You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. 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 this Board.

**Affidavit  
And  
Authorization For Release of Information**

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 Application for Physician 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'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

Applicant Photograph

Securely tape or glue in this square a current front-view 2" x 2" passport-type color photograph of yourself.

**NOTARY**

Dated \_\_\_\_\_ Signed \_\_\_\_\_

State of \_\_\_\_\_ County of \_\_\_\_\_

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of, \_\_\_\_\_ 20\_\_\_\_\_

My commission expires: \_\_\_\_\_ (NOTARY PUBLIC SIGNATURE & SEAL)

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

EMPLOYMENT CONTRACT

I, an applicant for \_\_\_\_\_  
(Applicant's Name)

Certification as a Radiologist Assistant, am employed by  
\_\_\_\_\_  
(Employer's Name)

for the period beginning \_\_\_\_\_  
(Month/Day/Year)

Termination of my contract will cause my Certification to become null and void.

\_\_\_\_\_  
Signature of Radiologist Assistant (Date)

\_\_\_\_\_  
Signature of Supervising Radiologist (Date)

Print Name of Physician \_\_\_\_\_

NOTE: A contract from each separate employer is required.

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

**APPLICATION BY PROPOSED PRIMARY SUPERVISING RADIOLOGIST**

Name in full \_\_\_\_\_  
(Last) (First) (Middle)

Address where RA will be supervised:

\_\_\_\_\_  
(Office Name)  
\_\_\_\_\_  
(Street)  
\_\_\_\_\_  
(City/State) (Zip Code) (Telephone Number)

Vermont Physician License #: \_\_\_\_\_

Hospital(s) where you have privileges:

Hospital(s)	Location
_____	_____
_____	_____
_____	_____

What arrangements have you made for supervision when you are not available:

\_\_\_\_\_  
\_\_\_\_\_

List the names and addresses of all Radiologist Assistants you currently supervise:

\_\_\_\_\_  
\_\_\_\_\_

**CERTIFICATE OF PROPOSED PRIMARY SUPERVISING RADIOLOGIST**

I hereby certify that, in accordance with 26 VSA, Chapter 52, I shall be legally responsible for all professional activities of \_\_\_\_\_, RA, while under my supervision. I further certify that the protocol attached to this application, and does not exceed the normal limits of my practice. I further certify that notice will be posted that a Radiologist Assistant is used, in accordance with 26 VSA, Chapter 52, Section 2863. I also affirm that I have read and will abide by all provisions of 26 VSA, Chapter 52, and Section 5 of the Rules of the Vermont Board of Medical Practice.

I further certify that I have read the statutes and Board rules governing Radiologist Assistants.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Proposed Primary Supervising Radiologist)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Radiologist Assistant)

STATE OF VERMONT - BOARD OF MEDICAL PRACTICE  
108 CHERRY STREET  
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**APPLICATION BY PROPOSED SECONDARY SUPERVISING RADIOLOGIST**

Name in full \_\_\_\_\_  
(Last) (First) (Middle)

Address where RA will be supervised:

\_\_\_\_\_  
(Office Name)  
\_\_\_\_\_  
(Street)  
\_\_\_\_\_  
(City/State) (Zip Code) (Telephone Number)

Vermont Physician License #: \_\_\_\_\_

Hospital(s) where you have privileges:

Hospital(s)	Location
_____	_____
_____	_____
_____	_____

What arrangements have you made for supervision when you are not available:

\_\_\_\_\_  
\_\_\_\_\_

List the names and addresses of all Radiologist Assistants you currently supervise:

\_\_\_\_\_  
\_\_\_\_\_

**CERTIFICATE OF PROPOSED SECONDARY SUPERVISING RADIOLOGIST**

I hereby certify that, in accordance with 26 VSA, Chapter 52, I shall be legally responsible for all professional activities of \_\_\_\_\_, R.A. while I am supervising him/her. I further certify that the protocol attached to this application, does not exceed the normal limits of my practice and that in accordance with 26 VSA, Chapter 52, Section 2863. I also affirm that I have read and will abide by all provisions of 26 VSA, Chapter 52, and Section 5 of the Rules of the Vermont Board of Medical Practice.

I further certify that I have read the statutes and Board rules governing Radiologist Assistants.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Proposed Secondary Supervising Radiologist)

## VERMONT BOARD OF MEDICAL PRACTICE RADIOLOGIST ASSISTANT PROTOCOL

A protocol means a written document detailing those areas of medical practice including duties and medical acts, delegated to the Radiologist Assistant by the supervising physician for whom the physician is qualified by education, training and experience. At no time shall the protocol of the Radiologist Assistant exceed the normal scope of either the primary or secondary supervising physician(s) practice.

Radiologist Assistants practice medicine with physician supervision. Radiologist Assistants may perform those duties and responsibilities, including the prescribing and dispensing of medical devices that are delegated by their supervising physician(s).

Radiologist Assistants shall be considered the agents of their supervising physicians in the performance of all practice-related activities, including but not limited to the ordering of diagnostic, therapeutic and other medical services.

It is the obligation of each team of physician(s) and the Radiologist Assistant(s) to insure that the written scope of practice submitted to the Board for approval clearly delineates the role of the Radiologist Assistant in the medical practice of the supervising physician. This should cover at least the following categories:

a) Narrative: A brief description of the practice setting, the types of patients and patient encounters common to this practice and a general overview of the role of the Radiologist Assistant in that practice.

b) Supervision: A detailed explanation of the mechanisms for on-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 patients 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 Radiologist Assistant's activities, retrospective chart review, co-signing of patient charts, and utilization of the services of non-supervising physicians and consultants.

c) Sites of Practice: A description of any and all practice sites (i.e. office, clinic, outpatient, hospital inpatient, industrial sites, schools, etc.). For each site, include a description of the RA's activities.

d) Tasks/Duties: A list of the RA's tasks and duties in the supervising physician's scope of practice.

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 Radiologist Assistant is qualified by education, training and experience to perform. Notwithstanding the above, the Radiologist Assistant should initiate emergency care when required while accessing back-up assistance. At no time should a particular task assigned to the-RA fall outside of the scope of practice of the supervising physician.

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

RADIOLOGIST ASSISTANT

VERIFICATION OF 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 medical practitioner.

I \_\_\_\_\_, on behalf of the \_\_\_\_\_

State Board of \_\_\_\_\_, certify that \_\_\_\_\_  
(or other authority)

was granted Certificate/License Number \_\_\_\_\_

to practice as a \_\_\_\_\_ in the State of \_\_\_\_\_

on the \_\_\_\_\_ day of \_\_\_\_\_

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

(AFFIX SEAL)

\_\_\_\_\_  
(Authorized Representative)

\_\_\_\_\_  
(Date)