Vermont Secretary of State
Office of Professional Regulation
Board of Osteopathic Physicians and Surgeons
National Life Bldg., North, FL 2
Montpelier, VT 05620-3402
Aprille Morrison, Licensing Board Specialist
Phone: 802-828-2373
Email: amorris@sec.state.vt.us

Instructions to Applicants
Applying for Licensure as an Osteopathic Physician

Your application must be complete before it will be sent to the Board for review. Please note that applications are valid for a period of one year.

All applicants must submit the following:

1. Completed Vermont application. (Pages 2 through 5)

2. Application fee of $500.00, payable to Vermont Secretary of State.
(Application fees are non-refundable.)

3. Certificate of Osteopathic Medical Education (page 6 of this application). Proof of graduation from an accredited college or university where you received your medical degree. Complete the top portion of the form and forward it to your school for completion.

4. Certified copy of your National Board Scores to be sent to this Office directly from the National Board of Osteopathic Medical Examiners (NBOME).

5. Internship Training Affidavit (page 7 of this application). Must be completed by an authorized staff member of the hospital where you served your internship.

6. Official Osteopathic Physician Profile Report from the American Osteopathic Association (AOA). You may request the profile report through the following link: https://www.doprofiles.org

7. Three Reference Forms (pages 8 and 9 of this application). To be completed by a chief of services and by two active physician staff members. Completed form is to be sent directly to this Office.

8. Verification of Good Standing (page 10 of this application). Applicant completes the top portion of the form and forwards it to every state in which you now hold or have ever held a license to practice medicine.

Please mail your completed application to the following address:

Office of Professional Regulation
Board of Osteopathic Physicians and Surgeons
National Life Building, North, Floor 2
Montpelier, VT 05620-3402

Vermont Secretary of State
Office of Professional Regulation
National Life Building, North FL 2
Montpelier VT 05620-3402

Aprille Morrison
Licensing Board Specialist
(802) 828-2373
amorris@sec.state.vt.us
www.vtprofessionals.org

Board of Osteopathic Physicians and Surgeons

Application for Licensure as a/an Osteopathic Physician

Applying on the basis of: _____ Examination _____ Licensed in another state (Endorsement)
(Use Ink or Typewritten only)

First Name (Legal name no nicknames)	MI	Last Name & Title (Jr., Sr., II, III, etc.)	Circle One:
			Mr. Mrs. Ms. Dr.
Previous Name(s) (Maiden)			

Social Security Number: _____/_____/_____** (*Providing your social security number (SSN) is mandatory, and requested under the authority granted by 42 U.S.C. §405(c)(2)(C). It will be used by the Departments of Taxes, Child Support, and the Department of Labor in the administration of Vermont law, to identify individuals affected by such laws. Your SSN is not disclosed as part of a public records request);*

OR

Passport Number: _____*** (*If you do not have a social security number you must provide a passport number as evidence that there is no attempt to procure a license fraudulently (3 V.S.A. §129a)*

Mailing Address:	**P.O. Box**	
	Street/Apt #	
	City/State/Zip	
	Country	

911 Address: (if different than mailing)	**P.O. Box**	
	Street/Apt #	
	City/State/Zip	

Phone:	**( ) -**	**Cell Phone:**	**( ) -**
Fax:	**( ) -**	**E-Mail:**	

Date of Birth	Gender: (Circle One)
	Female Male

List below every state in which you now hold, or have ever held, a license/certification to practice			
State	**License Number**	**Date Issued**	**Expiration Date**

Vermont Mandatory "Good Standing" Declarations

CHILD SUPPORT:

Child Support Orders, 15 V.S.A. § 795(c): As of the date of this application: (you must check one)	
	Not Applicable – I am not subject to a child support order
	I am in good standing*
	I am in compliance with a payment plan approved by the Office of Child Support
	I am **NOT** in good standing*

TAXES:

Tax Compliance (32 V.S.A. § 3113(b)): As of the date of this application: (you must check one)	
	Not Applicable – I have never lived or worked in Vermont and do not owe Vermont taxes
	I am in good standing*
	I am in compliance with a payment plan approved by the Vermont Department of Taxes
	I am **NOT** in good standing*

DISTRICT COURT FINES / JUDICIAL BUREAU:

Unpaid Judgments (4 V.S.A. § 1110(b&c)): As of the date of this application: (you must check one)	
	Not Applicable – I do not have any unpaid judgments
	I am in good standing* with the judicial bureau or district court for fines or penalties for a violation or criminal offense
	I am **NOT** in good standing*

* "Good standing" is defined in the statutes cited above. For more information, refer to the relevant statute specific to the particular question.

Vermont Mandatory Credential and Fitness Questions

Circle Yes or No for each of these questions. If the answer is Yes, follow the instructions provided.

Has Vermont or any other state, federal authority, or other jurisdiction (US or elsewhere) denied an application by you for a license, certificate, or registration to practice a profession or occupation? *If "Yes," you must attach a copy of the order or official notification of the action(s).*	Yes	No
Has Vermont or any other state, federal authority, or other jurisdiction (US or elsewhere) restricted, suspended, revoked, or taken any other disciplinary action against a license, certificate, or registration that you hold or held in any profession or occupation? *If "Yes," you must provide a copy of the order or official notification of the action.*	Yes	No
Have you ever surrendered a license, certificate, or registration to a licensing authority? *If "Yes," you must provide a detailed written explanation.*	Yes	No
Are you currently under investigation by a licensing authority? *If "Yes," you must provide a detailed written explanation and a copy of any available information from the licensing authority.*	Yes	No
Have you been convicted of a crime other than a minor traffic violation? (Note: Driving While Intoxicated and Driving Under the Influence are not "minor traffic violations.") *If "Yes," you must provide a detailed written explanation and attach the official court documents.*	Yes	No
Do you have any criminal charges pending against you in any jurisdiction (US or elsewhere)? *If "Yes," you must provide a detailed written explanation and attach a copy of the charging documents.*	Yes	No

Note: Vermont law requires that you report to the Office of Professional Regulation, a felony conviction or any conviction of a crime related to the practice of your profession; within 30 days. 3 V.S.A. § 129a(a)(11).

Do you have a physical or mental condition or disorder which in any way impairs or limits your ability to practice this profession with reasonable skill and safety? *If "Yes," you must have your health care provider submit a detailed statement explaining how you are able to practice safely.*	Yes	No
Does your use of alcohol, substances, or prescription medications impair or limit your ability to practice this profession with reasonable skill and safety? *If "Yes," you must provide a detailed written explanation.*	Yes	No
Are you currently addicted to or in any way dependent on alcohol or habit forming drugs? *If "Yes," you must provide a detailed written explanation.*	Yes	No
Have your hospital privileges ever been denied, conditioned, revoked or limited in any way? *If "Yes," provide a copy of any available information.*	Yes	No
Have you ever had any malpractice judgments or settlements against you? *If "Yes," provide a copy of applicable information.*	Yes	No

Medical Education

Name and Location of College/University Attended:	Degree Earned	Date

Training

List in reverse chronological order, residency or other post-graduate training. Give names, city and state of hospitals, exact dates (month/day/year), and type of training.

Name of Hospital	Address	Start Date	Complete Date	Type of Training

Hospital Privileges

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

Name of Hospital	Address	Start Date	Complete Date

References

Please indicate the names and titles of the individuals that will be completing and submitting Reference Forms to this Office.

Name	Title

Statement of Applicant

I certify, under the pains and penalties of perjury, that all information I have provided in this application is true and accurate. I understand that furnishing false information may constitute unprofessional conduct and result in the denial of my application or further disciplinary action. The maximum penalty for perjury is fifteen years in prison and/or a $10,000 fine. (13 V.S.A. §2901)

Signature of Applicant	Date

Vermont Secretary of State
Office of Professional Regulation
Board of Osteopathic Physicians and Surgeons
National Life Building, North, Floor 2
Montpelier, VT 05620-3402
802-828-2373

Certificate of Osteopathic Medical Education

Applicant: Complete the top portion of this page and forward it to your college/school for completion.

Applicant's Name:_____
(Last) (First) (Middle Initial) (Former)

Address:_____

Date of Birth:_____ Social Security Number:_____/_____/_____

Name of College:_____

Degree(s) Earned:_____ Date of Graduation:_____

Applicants Signature:_____ Date:_____

TO BE COMPLETED BY THE INSTITUTION GRANTING DEGREE(S): Please complete the bottom portion of this form and return it directly to the Vermont Board of Osteopathic Physicians and Surgeons at the address listed above.

Student's Name:_____

Name of Osteopathic College of Medicine:_____

Address of College:_____

Date of Admission:_____ Date all requirements for graduation were completed:_____

Date Doctorate of Osteopathic Medicine was granted:_____

Was this College of Medicine accredited by the American Osteopathic Bureau of Professional Education at the time of this student's graduation?	Yes	No

_____
Signature of Authorized Agent of the Institution

(Affix Seal Here)

_____
Title

_____
Date

Vermont Secretary of State
Office of Professional Regulation
Board of Osteopathic Physicians and Surgeons
National Life Building, North, Floor 2
Montpelier, VT 05620-3402
802-828-2373

Internship Training Affidavit

This form must be completed by an authorized staff member of the hospital where you served your internship.
Name of Applicant:_____ I hereby certify that _____, a graduate of _____, has satisfactory completed _____ year(s) internship in the _____ hospital. Said internship began on _____ and ended on _____.
I further certify that the hospital named above is approved for Intern Training by the Bureau of Hospitals of the American Osteopathic Association or the American Medical Association.

_____
Print Name of Authorized Person

(Affix Seal Here)

_____
Signature of Authorized Person

_____
Date

Vermont Secretary of State
Office of Professional Regulation
Board of Osteopathic Physicians and Surgeons
National Life Building, North, Floor 2
Montpelier, VT 05620-3402
802-828-2373

Reference Form

Both pages of the Reference Form to be completed by a Chief of Services and two from active Physician Staff Members to be sent directly to this Office at the above address.

Name of Applicant:_____

Name and title of the person completing this form:_____

The physician named above has applied to the Vermont Board of Osteopathic Physicians and Surgeons 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._____ was/is at _____ from_____

to _____. During that time, he/she was/is (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.

Section A.

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 and 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

Vermont Secretary of State
Office of Professional Regulation
Board of Osteopathic Physicians and Surgeons
National Life Building, North, Floor 2
Montpelier, VT 05620-3402

Name of Applicant:_____

Section B.

1. 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
If you answered "No" to the question above, please explain:_____ _____		
2. Does the applicant call upon consults when needed?	Yes	No
If you answered "No" to the question above, please explain:_____ _____		

Section C.

Important Note: If you answer "Yes" to any of the following questions, please explain in as much detail as possible.		
1. 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
2. Do you know of any pending professional misconduct proceedings or medical malpractice claims?	Yes	No
3. Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? (Note: Driving While Intoxicated (DWI) is **not** minor)	Yes	No
4. 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
5. Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures?	Yes	No
6. 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
7. Do you know of a failure of the applicant to complete a residency training program(s)?	Yes	No

Please feel free to use 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_____ for licensure in Vermont.
(Name of Physician)

Signed: _____ Date: _____

Reference Form (page 2 of 2)

Vermont Secretary of State
Office of Professional Regulation
Board of Osteopathic Physicians and Surgeons
National Life Building, North, Floor 2
Montpelier, VT 05620-3402

Verification of Good Standing

Applicant: Complete the top portion of this form and forward it to every state in which you now hold or have ever held a license to practice. Please print clearly.

Name of applicant:_____

Address:_____

_____
(City) (State) (Zip Code)

License number:_____ Date Issued:_____

I hereby authorize the Osteopathic Medical Licensing Authority in the State of _____ to furnish to the Vermont Board of Osteopathic Physicians and Surgeons the information requested below.

Applicant's Signature:_____ Date:_____

State Licensing Authority: Please complete the bottom portion of this form and return it directly to the Vermont Board of Osteopathic Physicians and Surgeons at the address above.

Licensing Board or Agency: This is to certify that the above-named individual was issued License Number _____ to practice as an Osteopathic Physician on (date issued): _____

Status of License: ( ) Active ( ) Inactive ( ) Lapsed ( ) Other:_____

Date License Expires/d: _____

Basis of Licensure:

( ) **Examination:** Please select the exam the physician took as well as indicate the year the examination was taken.

( ) COMLEX _____ ( ) COMVEX _____ ( ) NBOME _____ ( ) State Exam _____

( ) SPEX _____ ( ) USMLE _____ ( ) FLEX _____ ( ) Other _____

( ) **Endorsement** from _____ (Indicate state)

( ) **Waiver** – Indicate on what basis:_____

Was this applicant's school accredited by the American Osteopathic Association Bureau of Professional Education? (If "No" please explain)	Yes	No
Disciplinary Action: Has this license ever been revoked, suspended, limited, surrendered, restricted, placed on probation, encumbered in any way or is it currently under investigation?	Yes	No

Signature:_____

Title:_____

(SEAL)

State:_____

Date:_____