



**Secretary of State
Office of Professional Regulation**

**NATUROPATHIC PHYSICIANS
Certificate of Completion of Independent Review**

The following information is to be completed by the supervising physician. Please write legibly.

Last Name (Supervisee)	First Name	MI	VT License #

I possess an unencumbered Vermont license and have prescribed and administered prescription drugs under that license for at least five years.	Yes	No
I have reviewed at least _____ drug prescriptions issued by the supervisee named above.	Yes	No

(Circle one answer for each statement below.)

With respect to the review described, the supervisee's ability to safely prescribe and administer prescription drugs within his or her scope of practice is, in my judgment:

Good	Marginal	Inadequate
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With respect to the review described, the supervisee's ability to comply with federal and State statutes is, in my judgment:

Good	Marginal	Inadequate
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With respect to the review described, the supervisee's ability to comply with the applicable administrative rules of the Vermont Board of Pharmacy is, in my judgment:

Good	Marginal	Inadequate
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STATEMENT OF SUPERVISNG PHYSICIAN

I hereby certify that all information I have provided herein is true and accurate to the best of my knowledge

(Signature of Supervising Physician)	(Date)
(Print Name)	