ARIZONA BOARD OF MEDICAL EXAMINERS

1651 E. Morten, Suite 210
Phoenix, Arizona 85020
A.C. (602) 255-3751

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE THROUGH ENDORSEMENT AND SPEX WRITTEN EXAMINATION

FOR BOARD USE
DO NOT USE THIS SPACE

BOMEX

MAY - 9 1995

ALL FORMS PROVIDED MUST BE COMPLETED BY THE APPROPRIATE AGENCY AND RETURNED DIRECTLY TO THIS BOARD

INFORMATION

A. Arizona prescribes to the written Special Purpose Examination (SPEX) of the Federation of State Medical Boards of the United States which are offered in March; June; September; and December, annually The FILING DEADLINE date to each is November 30; March 1; May 30; and August 23, respectively and completed applications received after those dates will be assigned to the then next regularly scheduled examination.

B All candidates shall provide satisfactory evidence that·

1. He possess a good moral and professional reputation
2. He is physically and mentally able to engage safely in the practice of medicine.
3. He has not been found guilty of any act of unprofessional conduct; medical incompetency; or mentally or physically unable to engage safely in the practice of medicine.
4. He has not had disciplinary action taken against him by any other state, territory, district or country for reasons relating to his ability to engage safely and skillfully in the practice of medicine.

Applications not fully complete within one year from date of receipt, including participation in the SPEX examination are considered withdrawn.

APPLICATION INSTRUCTIONS
(Read Carefully)

In addition to the appropriate completion of the applicable sections of this application; the applicant will submit the following:

1. Evidence of name and date of birth· a photocopy of birth certificate; or documentary evidence for consideration (Visa, alien resident card, Passport, etc.)
2 Certified evidence of any legal name changes other than that shown on certificates filed in accordance with paragraph 1 above, (e.g., marriage certificate).
3 Photocopy of M.D. Degree Diploma; OR M B , B.S. Degree Diploma for foreign graduates.
4. Photocopy of the DD 214 Form of release from the U.S military or public health service. OR, if currently serving, have attached herewith a letter from any Commanding Officer setting forth the dates of active duty, assignments, and anticipated date of release from active duty.
5 Photocopies of any certificates awarded by any of the American medical specialty boards.
6 Photocopies of all certificates awarded upon completion of any internship, residency, fellowship or other post-graduate medical education undertaken in United States or Canadian hospitals; OR letters of certification of partial; past; or current training.

7. The name and address of all of your hospital affiliations for the five years prior to filing this application and the Chief of Staff or Chief of Service for each.
8. A statement of your exact whereabouts and nature of practice from date of graduation from medical school to the present, with specific month and year listed for each location. No period unaccounted for is allowed.
9. Cashier's Check or Money Order in U.S. Funds (personal checks not accepted), covering the statutory fee of $550.00 There are no refunds
10. Applicants, whose written examination; FLEX examination; National Board of Medical Examiners (NBME) or Licensing Medical Council of Canada (LMCC) certificates, upon which endorsement is sought was received more than ten years preceding the filing of this application, are required to submit to the SPEX examination.
11. Credentials submitted in foreign languages shall have affixed thereto a certified translation into English.
12. Separated or Mutilated Applications are not acceptable and will require refiling.
13. Requests for exemptions or waivers of any portion of this application will be denied and will delay your consideration for licensure
14. **NOTE:** All credentials submitted must remain the property of the Arizona Board of Medical Examiners and NONE will be returned except original Certificates of Naturalization or the applicant's **triplicate** copy of Declaration of Intention.
15. Photocopies shall not exceed 8 ½ inches by 11 inches in size.

UNITED STATES OR CANADIAN MEDICAL SCHOOL GRADUATES

Graduates of medical schools located in the United States or Canada which were approved by the Council on Medical Education of the American Medical Association, the Canadian Medical Council, or the Association of American Medical Colleges, will forward forms numbered I, II, and III to the appropriate agency with the request that they be completed and returned directly to the Arizona Board of Medical Examiners.

ALL OTHER MEDICAL SCHOOL GRADUATES

Graduates of medical schools located outside the United States or Canada will forward Forms numbered I, II, III, and IV as may be applicable, to the appropriate agency with the request that they be completed and returned to the Arizona Board of Medical Examiners.

Note: Applications will not be processed not considered until ALL required forms are completed and returned directly to the Arizona address provided.

APPLICATION

(To be completed, signed by applicant and notarized. All questions MUST be answered completely.)

1. Present Legal Name: PRINT OR TYPE RAMOS (Last) William (First) DOUGLAS (Middle) _____ (Maiden)
   (a) Other names used: NONE
2. Address: Residence: [redacted] (No.) (Street) (City) (State) (Zip Code) (Phone)
   Office 3205 (No.) ARLINGTON AVE (Street) BRONX (City) NY (State) 10463 (Zip Code) (718)548-8151 (Phone)
3. City and State of Birth [redacted] Month, Day and Year of Birth [redacted]
4. In what states or provinces have you applied for or been granted license or registration? If more than two, attach separate listing If license not issued, so state.
   (a) See Separate List (Specify State Board) (Date of Application) (Result) (Certificate No.) (Date Issued) (Specify if by Written Examinations or on Credentials)
   (b) _____ (Specify State Board) (Date of Application) (Result) (Certificate No.) (Date Issued) (Specify if by Written Examinations or on Credentials)
5. Has any disciplinary or rehabilitative action including reprimand, censure, probation, restriction, limitation, suspension, stipulation, written consent agreement or revocation ever been taken against you by any state licensing (including other health professions) Board? NO (Answer)
6. Have any actions, restrictions, limitations (including probation or academic probation) been taken while you were participating in any type of training program or by any health care provider? NO (Answer)
7. Have you ever been charged with a violation of any law, statute, rule or regulation of any domestic or foreign governmental agency? (EXCEPT MOTOR VEHICLES) NO (Answer)
8. Has there been any action initiated against you by or through any medical board or association? NO (Answer)

9. Have you ever had a medical license revoked; suspended; limited; restricted; placed on probation; voluntarily surrendered or canceled during an investigation or in lieu of disciplinary action, entered into a consent agreement or stipulation?

NO
(Answer)

10. Have you ever had hospital privileges revoked; denied; suspended or restricted in any way?

NO
(Answer)

11. Have you ever been named as a defendant in any malpractice matter which resulted in a settlement or judgement against you in excess of $20,000?

YES
(Answer)

12. Have you ever been convicted of Medicare or Medicaid fraud or received sanctions (including restriction, suspension or removal from practice) imposed by any agency of the federal government?

NO
(Answer)

13. Have you ever had your ability to prescribe, dispense or administer medications limited, restricted, modified, denied, surrendered or revoked by a federal or state agency?

NO
(Answer)

Note: In the event the response to any of the questions numbered 5 through 13 is YES, the applicant will file with the application a detailed report concerning the above matters; including, any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the results of any hearings, and the disposition of such charge(s). Provide the name and address of applicant's insurance carrier and the name and address of patient's attorney. IN ADDITION, the applicant must provide that certified photocopy(ies) of any hearings, settlements or judgements be submitted to this Board.

14. Have you ever taken a leave of absence (other than for pregnancy) during medical school, training, or any other practice?

NO

15. Do you have any chronic ailment communicable to others?

[redacted]
(Answer)

16. Do you have any medical condition which in any way impairs or limits your ability to safely practice any field of medicine. [redacted]

Ability to practice medicine is to be construed to include all of the following:

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, emotion or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug-addiction and alcoholism.

17 Within the last ten years, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?

[redacted]
(Answer)

Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?

[redacted]
(Answer)

If you answered "YES" to any part of this question, please provide details on a Supplemental Form, including date(s) of diagnosis or treatment, a description of the course of treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment.

18. List Internships, Residency and Fellowship training -chronologically showing institution, address and type of program, and dates. Attach separate listing if needed.

See Separate Sheet

19. Are you American Board certified? YES Specialty OB/GYN, PATHOLOGY (AP-CP-FP)

20. Have you completed the educational requirements for any of the American medical specialty boards? If so, which? YES (SEE #19)

21. Exact whereabouts and nature of practice from date of graduation from medical school to the present, with specific MONTH and YEAR listed for each. No period unaccounted for is allowed. Attach separate listing if needed.

At NEW YORK (City) NY (State) from 7/70 to 6/75

At VANDENBERG AFB (City) CA (State) from 7/75 to 7/78

At RENO (City) NV (State) from 8/78 to 6/86

At HANOVER (City) NH (State) from 7/86 to 6/90

At NEW YORK (City) NY (State) from 7/90 to PRESENT

At _____ (City) _____ (State) from _____ to _____

22. In the event you are successful in obtaining a license to practice medicine by this application, have you selected a location?

YES Where? PHOENIX, GLENDALE, SCOTSDALE

Solo or in Association with? Solo

23. What is your intended specialty practice? GYNECOLOGY AND PATHOLOGY

24. What branch of the United State Armed Forces have you served with, if any, including USPHS? USAF

Active duty? From 1/67 (Month and Year) to 7/78 (Month and Year)

STATE OF _____

County of _____ } SS

The applicant _____
(PRINT OR TYPE) (Name in Full)

being first duly sworn upon his oath deposes and says that he is the person herein named subscribing to this application; that he has read the complete application, knows the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that he is the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which the applicant is aware and that the applicant is aware and that the applicant is the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present and future), and all government agencies (local, state, federal or foreign) to release to the Arizona Board of Medical Examiners or its successors any information, files or records requested by that Board in connection with this application; or mental ability to safely engage in the practice of medicine. I further authorize the Arizona Board of Medical Examiners or its successors any information, files or records requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of medicine. I further authorize the Arizona Board of Medical Examiners or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure I further acknowledge that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

Signature of Applicant William Payne M.D., M.D.

(NOTARIAL SEAL)

Subscribed and sworn to before me this 8 day of May 19 95

Notary Signature J. Michael Gaudreau (Notary Public) My Commission expires

J. MICHAEL GAUDREAU
Notary Public, New Hampshire
My Commission Expires June 25, 1996

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MAY - 9 1995

FOR OFFICE USE ONLY

Application Rec'd	19	Application Processed by	CG
Application Completed	19	Application Checked by	bd
Form No. I Rec'd 10/5	19 95	Application Approved 11/14	19 95
Form No. II Rec'd 6/2	19 95	By	
Form No. III Rec'd 5/15	19 95	License Issued November 17,	19 95
Form No. III Rec'd 5/19	19 95	License No. 23599	
Form No. III Rec'd 5/15	19		
Form No IV Rec'd	19		
Investigation Completed	19		

ARIZONA BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

APPLICANTS: List all hospital affiliations for the past five (5) years, including moonlighting and courtesy staff affiliations.

List all employment with medical agencies of employment, e.g., physician placement group; emergency medical group radiology group; etc.

✓ 1) HOSPITAL: LA GUARDIA HOSPITAL 6/8/95

ADDRESS: 102-01 66TH ROAD (City) FOREST HILLS (State) NY (Zip Code) 11375

DATE OF STAFF MEMBERSHIP: 1992

TYPE OF STAFF MEMBERSHIP: ATTENDING

✓ 2) HOSPITAL: ST. LUKES / ROOSEVELT HOSPITALS 7/26/95

ADDRESS: 1000 TENTH AVE (City) NEW YORK (State) NY (Zip Code) 10019

DATE OF STAFF MEMBERSHIP: JAN 1994

TYPE OF STAFF MEMBERSHIP: ATTENDING

N/A 3) HOSPITAL: ELMHURST HOSPITAL dell memo

ADDRESS: 79-01 BROADWAY C ANNEX (City) ELMHURST (State) NY (Zip Code) 11373

DATE OF STAFF MEMBERSHIP: JAN 1995

TYPE OF STAFF MEMBERSHIP: ATTENDING

4) HOSPITAL:

ADDRESS: (City) (State) (Zip Code)

DATE OF STAFF MEMBERSHIP:

TYPE OF STAFF MEMBERSHIP:

✓ 5) MEDICAL AGENCY OF EMPLOYMENT: CHOICES WOMENS MEDICAL GROUP

ADDRESS: 97-77 QUEENS BLVD (City) FOREST HILLS (State) NY (Zip Code) 11374 10/19/95

DATE OF EMPLOYMENT: DEC 1990 - PRESENT

6) MEDICAL AGENCY OF EMPLOYMENT:

ADDRESS: (City) (State) (Zip Code)

DATE OF EMPLOYMENT:

THIS IS AN IMPORTANT RECORD
SAFEGUARD IT

1 LAST NAME FIRST NAME MIDDLE NAME	2 SEX	3 SOCIAL SECURITY NUMBER	4 DATE OF BIRTH	YEAR	MONTH	DAY
RAMOS WILLIAM DOUGLAS	M	[redacted]		[redacted]		

5 DEPARTMENT COMPONENT AND BRANCH OR CLASS	6a GRADE RATE OR RANK	b PAY GRADE	7 DATE OF RANK	YEAR	MONTH	DAY
RegAF (MC)	*MAJ	0-4		1972	Dec	11

8a SELECTIVE SERVICE NUMBER	b SELECTIVE SERVICE LOCAL BOARD NUMBER CITY STATE AND ZIP CODE	c HOME OF RECORD AT TIME OF ENTRY INTO ACTIVE SERVICE
NA	NA	[redacted]

9a TYPE OF SEPARATION	b STATION OR INSTALLATION AT WHICH EFFECTED
Discharge	Vandenberg AFB, CA

c AUTHORITY AND REASON	d EFFECTIVE DATE	YEAR	MONTH	DAY
----------		1978	Jun	29

e CHARACTER OF SERVICE	f TYPE OF CERTIFICATE ISSUED	10 REENLISTMENT CODE
HONORABLE	DD Form 256AF	----------

11 LAST DUTY ASSIGNMENT AND MAJOR COMMAND	12 COMMAND TO WHICH TRANSFERRED
USAF Hospital, Vandenberg (SAC)	NA

13 TERMINAL DATE OF RESERVE/MSS OBLIGATION YEAR	MONTH	DAY	14 PLACE OF ENTRY INTO CURRENT ACTIVE SERVICE (City, State and/or Country)	15 DATE ENTERED ACTIVE DUTY THIS PERIOD YEAR	MONTH	DAY
NA			New York, NY 10463	1967	Jan	11

16a PRIMARY SPECIALTY NUMBER AND TITLE	b RELATED CIVILIAN OCCUPATION AND D O T NUMBER
9496-Obstetrician & Gynecologist	Obstetrician 070.108

17a SECONDARY SPECIALTY NUMBER AND TITLE	b RELATED CIVILIAN OCCUPATION AND D O T NUMBER
NA	NA

18 RECORD OF SERVICE	YEARS	MONTHS	DAYS
a NET ACTIVE SERVICE THIS PERIOD	11	05	19
b PRIOR ACTIVE SERVICE	00	00	00
TOTAL ACTIVE SERVICE a+b	11	05	19
d PRIOR INACTIVE SERVICE	00	10	07
TOTAL SERVICE FOR PAY e+f	12	03	26
f FOREIGN AND/OR SEA SERVICE THIS PERIOD	00	00	00

19 INDOCHINA OR KOREA SERVICE SINCE AUGUST 5 1964	20 HIGHEST EDUCATION LEVEL SUCCESSFUL COMPLETED (a) or
☐ YES ☒ NO	SECONDARY/HIGH SCHOOL 12 YRS (Last grade) COLLEGE 8 HS

21 TIME LOST (Preceding Two Years)	22 DAYS ACCRUED LEAVE PAID	23 SERVICEMEN'S GROUP LIFE INSURANCE COVERAGE	24 DISABILITY SEVERANCE PAY	25 PERSONNEL SECURITY INVESTIGATION a TYPE	b DATE COMPLETED
NO TIME LOST	1.0	☐ $15 000 ☐ $5 000 (X) #20,000 ☐ $10 000 ☐ NONE	☒ NO ☐ YES AMOUNT NA	*BI	20 Jan 65

26 DECORATIONS MEDALS BADGES COMMENDATIONS CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED

AFOUA W/1OLC, AFR 900-48. SAEMR W/1 Device, AFR 900-48. NDSM, AFR 900-48. AFLSA, AFR 900-48.

27 REMARKS

Blood Group: [redacted] AFSN: AF11430656 DAFSC: 9496.
*Item 25a cont: 1st Dist/OSI Westover AFB, MA 01022.

"Individual requests a copy of DD Form 214." LPR

28 MAILING ADDRESS AFTER SEPARATION (Street, RFD, City, County, State and Zip Code)

[redacted]

29 SIGNATURE OF PERSON BEING SEPARATED

William D. Ramos M.D.

30 TYPED NAME, GRADE AND TITLE OF AUTHORIZING OFFICER

JAMES FREDERICK JR, 2LT, USAF
Chief, Quality Force Section

31 SIGNATURE OF OFFICER AUTHORIZED TO SIGN

James Frederick Jr.

DD FORM 1 NOV 73 214

THIS IS AN IMPORTANT RECORD
SAFEGUARD IT

REPORT OF SEPARATION FROM ACTIVE DUTY

I.

The American Board of Pathology

• A Member Board of the American Board of Medical Specialties •

Please address all communications to

Office of The American Board of Pathology

Mailing address

P O Box 25915
Tampa, Florida 33622-5915
Tel 813/286-2444
FAX 813/289-5279

Express address

One Urban Centre, Suite 690
4830 West Kennedy Boulevard
Tampa, Florida 33609-2571

7 Augst 1995

Board of Medical Examiners Of The State Of Arizona
1651 East Morten Avenue
Suite 210
Phoenix, AZ 85020

To Whom It May Concern:

William Douglas Ramos, M.D. is a diplomate of The American Board of Pathology having been certified in combined Anatomic and Clinical Pathology in August 1990.

Dr. Ramos received a certificate for special qualification in Forensic Pathology in June 1991.

Sincerely yours,

William H. Hartmann, M.D.
Executive Vice President

WHH/dr

SEAL

RECEIVED B.O.M.E.X.
AUG 17 95

American Board of Obstetrics & Gynecology

Robert C Cefalo, M D , Ph D
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Miami, FL
Vice President

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Chapel Hill, NC
Director of Evaluation

Norman F Gant, M D
Executive Director
2915 Vine Street
Dallas, TX 75204-1069
Phone (214) 871-1619
Fax (214) 871-1943

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Baltimore, MD

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Baltimore, MD

Gerson Weiss, M D
Newark, NJ
Directors

Incorporated 1930

A founding member of
The American Board of
Medical Specialties

July 24, 1995

Board of Medical Cexaminers
Of the State of Arizona
1651 East Morten Avenue, Suite 210
Phoenix, AZ 85020

Reference: WILLIAM DOUGLAS RAMOS, MD
Diplomate #1562

Dear Administrator:

Dr William Douglas Ramos is a **diplomate** of The American Board of Obstetrics & Gynecology, Inc (ABOG) certified in 1976.

This office responds to inquiries concerning the status of physicians in the certification process according to the following:

1 An individual is a registered residency graduate with ABOG when, upon application, ABOG rules that he/she has fulfilled the requirements to take the written examination.

2 An individual may achieve active candidate status by passing the written examination This status is limited to six years and if expired may be regained by repeating and passing ABOG's written examination.

3 An individual becomes a **diplomate** of ABOG when he/she has fulfilled all requirements, has satisfactorily completed the written and oral examinations and has been awarded ABOG's certifying diploma. Diplomas issued in 1986 and thereafter are valid for 10 years.

Sincerely yours,

Norman F. Gant, M.D.
Executive Director

NFG:ks

The American Board of Pathology

Herewith certifies that

William D. Ramos, M.D.

Has pursued an accepted course of graduate study and clinical work and has demonstrated proficiency to the satisfaction of the Board of Trustees.

Therefore on the fourth day of June, 1991,

The American Board of Pathology

has granted this certificate of Special Qualification in Pathology:

Forensic Pathology

BOMEX

MAY - 9 1995

SD-9[illegible]-032

Charles A. Hirsch, President
Thomas J. Gill III, Vice-President
W. Hoefnagel, Secretary
Frank B. Walker, Treasurer

Ramzi Cotran
M. Helwig
Howard M. Ramsley
B. Reed
Frederick R. Davey
John A. Mann
Jack P. Strong
John A. Washington

The American Board of Pathology

Herewith certifies that

William Douglas Ramos, M.D.

Has pursued an accepted course of graduate study and clinical work and has demonstrated proficiency to the satisfaction of the Board of Trustees.

Therefore on the thirtieth day of August, 1990,

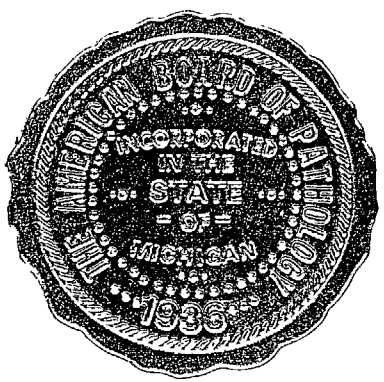
The American Board of Pathology

has granted this certificate of qualification for the practice of

Anatomic and Clinical Pathology

BOMEX

MAY - 9 1995



90-124

Jack P. Strong
President

Charles A. Hirsch
Vice-President

Thomas J. Gill III
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American Board of Obstetrics and Gynecology

DIPLOMATE

COMPOSED OF REPRESENTATIVES OF THE
AMERICAN GYNECOLOGICAL SOCIETY
AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS
SECTION ON OBSTETRICS AND GYNECOLOGY, AMERICAN MEDICAL ASSOCIATION
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
ASSOCIATION OF PROFESSORS OF GYNECOLOGY-OBSTETRICS
CERTIFIES THAT

WILLIAM DOUGLAS RAMOS

HAVING PURSUED AN ACCEPTED COURSE OF GRADUATE STUDY AND CLINICAL WORK, HAS MET THE STANDARDS AND QUALIFICATIONS AND PASSED THE EXAMINATIONS REQUIRED BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC. HE HAS THEREBY DEMONSTRATED TO THE SATISFACTION OF THIS BOARD THAT HE IS POSSESSED OF SPECIAL KNOWLEDGE, AND BY THE AWARD OF THIS DIPLOMA HIS PROFICIENCY IN THE SPECIALTY OF OBSTETRICS AND GYNECOLOGY IS RECOGNIZED AND HE IS AN ACKNOWLEDGED DIPLOMATE OF THIS BOARD

NOVEMBER 5, 1976

PRESIDENT

SECRETARY AND TREASURER

CHAIRMAN OF THE BOARD

BOMEX
MAY - 9 1995

FORM I

MEDICAL COLLEGE CERTIFICATION

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by the medical school granting the medical degree This is your authority to release any information in your files of record, favorable or otherwise, DIRECT TO THE BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 1651 EAST MORTEN AVENUE, SUITE 210, PHOENIX, ARIZONA 85020. Your early response will be appreciated.

Name: WILLIAM D. RAMOS, M.D. William Ramos M.D., M.D.
(Please Print or Type) (Signature)

Address: [redacted] [redacted]
(Street) (City and State)

Date: 8/15/95 CLASS OF 1970

(DO NOT DETACH)

(This section with a current photograph of the applicant shall be forwarded to and completed by an officer of the medical school granting the medical degree. Please indicate to your medical school that this completed form must be returned to the Arizona Board of Medical Examiners.)

This is to certify that William D Ramos
(Full Name of Student)

whose photograph is attached hereto, was granted the degree of MD by SUNY Health Science Center at Brooklyn (formerly Downstate Medical Center) on June 3 19 70
(Full Name of School or College of Medicine as it appears on the Applicant's Medical degree diploma)

that the date of his/her matriculation in medical school was September 12, 1966; and that he/she attended 34 (Number) full courses of medical lectures comprising 9 (Number) months each as verified be the attached certified copy of his/her transcripts.

1 Was applicant ever required to repeat any segment of training? _____ If YES, which part(s)? _____

2 Was applicant ever placed on probation, restricted or limited? _____ If YES, please attach a written explanation.

3 Was there any reason not to continue applicant in the training program? _____ If YES, please attach a written explanation.

4 Did the applicant have any medical condition which in any way impaired or limited his/her ability to safely practice any field of medicine? Yes [redacted] No [redacted]

Ability to practice medicine is to be construed to include all of the following:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aide 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, HIV disease, tuberculosis, drug addiction and alcoholism.

5. Was the applicant ever diagnosed with or treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? Yes [redacted] No [redacted]

(OVER)

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OCT -5 95

Has the applicant ever been admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? Yes [redacted] No [redacted]

If "YES" to any part of this question, please provide details on a Supplemental Form.

6. Did applicant ever take a leave of absence (other than for pregnancy) during medical school, training or any other practice? _____If YES, please attach a written explanation.

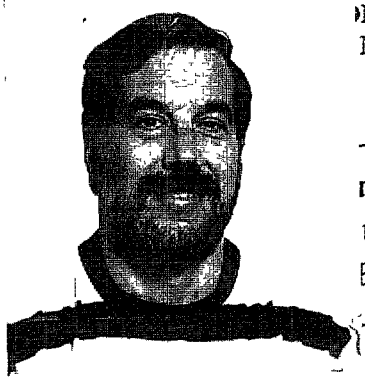
7. Were applicant's final evaluations in every category rated satisfactory and/or above? _____If NO, please attach certified photocopy of evaluation, together with written explanation.

Signed _____, M.D.

Dean
President
Secretary
Registrar
of _____ (SEAL OF COLLEGE)

Date August 13, 19 95

Address: 450 Clarkson Avenue Bklyn NY 11203



DIRECT to:
Medical Examiners, 1651 E. Morten Avenue, Suite #210, Phoenix, Arizona 85020

nt must assume the responsibility for completion of this form and is that it must be fully completed and forwarded to the Arizona Board Examiners before any application may be considered.

Information is limited to Academic Records Only

Division of Student Affairs
Office of the Registrar

State University of New York
Health Science Center at Brooklyn

450 Clarkson Avenue, Box 98
Brooklyn, New York 11203-2098
718-270-1875

DATE: SEPTEMBER 9, 1995

TO WHOM IT MAY CONCERN:

This is to certify that WILLIAM RAMOS attended the State University of New York Health Science Center at Brooklyn as a matriculated student from 9/12/66 to 6/3/70 at which time a M D degree was conferred.

Sincerely,

Sophie Christoforou
Assistant Dean for Student Affairs
and Registrar

STATE UNIVERSITY OF NEW YORK

DOWNSTATE MEDICAL CENTER

COLLEGE OF MEDICINE

ON THE RECOMMENDATION OF THE FACULTY
AND BY VIRTUE OF THE AUTHORITY VESTED IN THEM
THE TRUSTEES OF THE UNIVERSITY HAVE CONFERRED ON

WILLIAM DOUGLAS RAMOS

THE DEGREE OF

DOCTOR OF MEDICINE

AND HAVE GRANTED THIS DIPLOMA AS EVIDENCE THEREOF

GIVEN IN THE CITY OF NEW YORK IN THE STATE OF NEW YORK
IN THE UNITED STATES OF AMERICA ON THE THIRD DAY OF JUNE
ONE THOUSAND NINE HUNDRED AND SEVENTY

Elisabeth Luce Moore
Chairman of the Board of Trustees

Samuel B. Gould
Chancellor of the University

George M. Shipley
Chairman of the Medical Center Council

STATE UNIVERSITY OF NEW YORK · LET EACH BECOME ALL HE IS CAPABLE OF BEING · 1948

Joseph K. Hill
President of the Medical Center and Dean of the College of Medicine

FORM III

POSTGRADUATE TRAINING CERTIFICATION

TO WHOM IT MAY CONCERN:

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by each hospital wherein I participated in an approved post-graduate training program in the United States or Canada. This is your authority to release any information in your files of record, favorable or otherwise, DIRECT TO THE BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 1651 EAST MORTEN AVENUE, SUITE 210, PHOENIX, ARIZONA 85020. Your early response will be appreciated.

Name: William D. Ramos, M.D. (Please Print or Type) William D. Ramos M.D. (Signature), M.D.

Address: [redacted] (Street) [redacted] (City and State)

Date: 4/29/95

(DO NOT DETACH)

(This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) a program approved post-graduate training in the United States or Canada.)

This is to certify that Dr William D. Ramos (Name of Applicant in Full), M.D. undertook and satisfactorily completed a full term approved program of 54 (Number) months in the: State University / Kings County Hosp. (Full Name and Complete Address of Hospital) 451 Clarkson Ave. Bklyn. N.Y. 11203

in the field of Obs/GYN from 7/1/70 (Date) to 12/31/74 (Date/Anticipated Date)

and that the said program was approved for post-graduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada. YES X NO _____

1. Was applicant ever required to repeat any segment of training? NO If YES, which part(s)? _____
2. Was applicant ever placed on probation, restricted or limited? NO If YES, please attach a written explanation.
3. Was there any reason not to continue applicant in the training program? NO If YES, please attach a written explanation.
4. Did the applicant have any medical condition which in any way impaired or limited his/her ability to safely practice any field of medicine? Yes [redacted] No [redacted]

Ability to practice medicine is to be construed to include all of the following:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aide 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,

TUMBLE

mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

5 Was the applicant ever diagnosed with or treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? Yes [redacted] No [redacted]

Has the applicant ever been admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? Yes [redacted] No [redacted]

If "YES" to any part of this question, please provide details on a Supplemental Form.

6 Did applicant ever take a leave of absence (other than for pregnancy) during medical school, training or any other practice? No If YES, please attach a written explanation.

7. Were applicant's final evaluations in every category rated satisfactory and/or above? Yes. If NO, please attach certified photocopy of evaluation, together with written explanation.

Signed [signature]

Title Assistant Director

Address: KINGS COUNTY HOSPITAL CENTER
OFFICE OF HOUSE STAFF AFFAIRS
451 Clarkson Avenue Box 39
Brooklyn, NY 11203

(SEAL OF HOSPITAL)
(So indicate if none)
None
See letter

Date May 11, 19 95

Revised 2/95 Reorder # IPS 40169

The applicant must assume the responsibility for completion of this form and is forewarned that it must be fully completed and forwarded to the Arizona Board of Medical Examiners before any application may be considered.

State University-Kings County Hospital Center

STATE UNIVERSITY OF NEW YORK
DOWNSTATE MEDICAL CENTER

NEW YORK CITY
HEALTH AND HOSPITALS CORPORATION

Awards this certificate to William Douglas Ramos, M.D.

for satisfactory performance of duties at this hospital

as Intern, majoring in Obstetrics-Gynecology

from July 1, *1970 to* June 30, *1971*

In Witness Whereof, *the undersigned have affixed their signatures and the seals of the Health and Hospitals Corporation and the State University of New York this* 30th *day of* June *1971*

BOMEX
MAY - 9 1995

CHIEF OF SERVICE

PRESIDENT, MEDICAL BOARD
KINGS COUNTY HOSPITAL CENTER

PRESIDENT,
DOWNSTATE MEDICAL CENTER

EXECUTIVE DIRECTOR,
KINGS COUNTY HOSPITAL CENTER

PRESIDENT, NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

State University-Kings County Hospital Center

STATE UNIVERSITY OF NEW YORK
DOWNSTATE MEDICAL CENTER

NEW YORK CITY
HEALTH AND HOSPITALS CORPORATION

Awards this certificate to **William Douglas Ramos, M.D.**

for satisfactory performance of duties at this hospital

as **Resident in Obstetrics/Gynecology**

from *July 1, 1971* *to* *December 31, 1973*

In Witness Whereof, the undersigned have affixed their signatures and the seals of the Health and Hospitals Corporation and the State University of New York this *31st* *day of* *December, 1973*

BOMEX
MAY - 9 1995

James H. Dolker Jr.
CHIEF OF SERVICE

Benton D. King
PRESIDENT, MEDICAL BOARD
KINGS COUNTY HOSPITAL CENTER

Colin D. Plimpton
PRESIDENT,
DOWNSTATE MEDICAL CENTER

EXECUTIVE DIRECTOR,
KINGS COUNTY HOSPITAL CENTER

State University-Kings County Hospital Center

STATE UNIVERSITY OF NEW YORK
DOWNSTATE MEDICAL CENTER

NEW YORK CITY
HEALTH AND HOSPITALS CORPORATION

Awards this certificate to **William Douglas Ramos, M.D.**

for satisfactory performance of duties at this hospital

as **Chief Resident in Obstetrics/Gynecology**

from *January 1, 1974* *to* *December 31, 1974*

In Witness Whereof, *the undersigned have affixed their signatures and the seals of the Health and Hospitals Corporation and the State University of New York this* *31st* *day of* *December, 1974*

BOMEX
MAY - 9 1995

CHIEF OF SERVICE

PRESIDENT, MEDICAL BOARD
KINGS COUNTY HOSPITAL CENTER

Calvin Plimpton
PRESIDENT,
DOWNSTATE MEDICAL CENTER

EXECUTIVE DIRECTOR,
KINGS COUNTY HOSPITAL CENTER

KINGS COUNTY HOSPITAL CENTER
HOUSE STAFF AFFAIRS
451 CLARKSON AVENUE, BROOKLYN, NY 11203

Tel. *(718) 245-2026,27*
(718) 245-4381,87
Fax# *(718) 245-4062*

Janet Goldson- McKenzie
Assistant Director

Room B-1155

May 11, 1995

TO WHOM IT MAY CONCERN:

Please be advised that Kings County Hospital Center does not have an official Seal. The Seal is under the jurisdiction of The New York City Health & Hospitals Corporation.

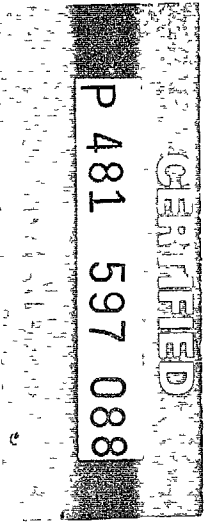
Sincerely,

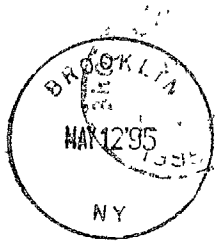
Janet Goldson-McKenzie
Assistant Director
Office of Professional Affairs

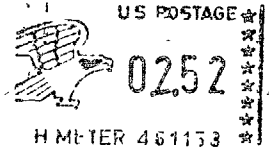
JGMcK/sek

NEW YORK CITY
HEALTH AND HOSPITALS CORPORATION
KINGS COUNTY HOSPITAL CENTER
451 CLARKSON AVENUE
BROOKLYN, N.Y. 11203

CODE
[39]







Board of Medical Examiners
State of Arizona
1651 East Morten Ave.
Phoenix, Arizona 85020

FORM III

POSTGRADUATE TRAINING CERTIFICATION

TO WHOM IT MAY CONCERN:

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by each hospital wherein I participated in an approved post-graduate training program in the United States or Canada. This is your authority to release any information in your files of record, favorable or otherwise, DIRECT TO THE BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 1651 EAST MORTEN AVENUE, SUITE 210, PHOENIX, ARIZONA 85020. Your early response will be appreciated.

Name: William D. RAMOS , M.D. William D. Ramos M.D. , M.D.
(Please Print or Type) (Signature)

Address: [redacted]
(Street) (City and State)

Date: 4/28/95

(DO NOT DETACH)

(This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) a program approved post-graduate training in the United States or Canada.)

This is to certify that William D. Ramos, M.D. undertook and
(Name of Applicant in Full)

satisfactorily completed a full term approved program of 48 months in the: Dartmouth-Hitchcock Medical
(Number) (Full Name and Complete Address of Hospital)

Center, 1 Medical Center Drive, Lebanon, NH 03756-001

in the field of Pathology from 7/1/86 to 6/30/90
(Date) (Date/Anticipated Date)

and that the said program was approved for post-graduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada. YES _____ NO _____

1. Was applicant ever required to repeat any segment of training? NO If YES, which part(s)? _____

2. Was applicant ever placed on probation, restricted or limited? NO If YES, please attach a written explanation.

3. Was there any reason not to continue applicant in the training program? NO If YES, please attach a written explanation.

4. Did the applicant have any medical condition which in any way impaired or limited his/her ability to safely practice any field of medicine? Yes [redacted] No [redacted]

Ability to practice medicine is to be construed to include all of the following:

The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and

The ability to communicate those judgments and medical information to patients and health care providers, with or without the use of aids or devices, such as voice amplifiers; and

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TUMBLE

mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

5. Was the applicant ever diagnosed with or treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? Yes [redacted] No [redacted]

   Has the applicant ever been admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? Yes [redacted] No [redacted]

If "YES" to any part of this question, please provide details on a Supplemental Form.

6. Did applicant ever take a leave of absence (other than for pregnancy) during medical school, training or any other practice? NO _____ If YES, please attach a written explanation.

7. Were applicant's final evaluations in every category rated satisfactory and/or above? YES If NO, please attach certified photocopy of evaluation, together with written explanation.

Signed _____ (SEAL OF HOSPITAL)
(So indicate if none)

Title DIRECTOR, PATHOLOGY RESIDENCY PROGRAM

Address: DARTMOUTH-HITCHCOCK MEDICAL CTR, LEBANON, NH Date MAY 12, 1995

Revised 2/95 Reorder # IPS 40169

The applicant must assume the responsibility for completion of this form and is forewarned that it must be fully completed and forwarded to the Arizona Board of Medical Examiners before any application may be considered.

Dartmouth-Hitchcock Medical Center

This will certify that

William Douglas Ramos, M.D.

has faithfully served as

Resident in Pathology

at the

Dartmouth Medical School Affiliated Institutions

from July 1, 1986 through June 30, 1990

in testimony whereof we affix our signatures

at Hanover, New Hampshire

BOMEX
MAY - 9 1995

Robert W. Colleran
Dean

Howard M. Ramsley
Medical Director

John L. Adams
Acting Chair, Department of Pathology

Alan R. Schned
Director Pathology Residency Training Program

FORM III

POSTGRADUATE TRAINING CERTIFICATION

TO WHOM IT MAY CONCERN:

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Name: William O. RAMOS , M.D. William O. Ramos M.D. , M.D.
(Please Print or Type) (Signature)

Address: [redacted] [redacted]
(Street) (City and State)

Date: 4/28/95

(DO NOT DETACH)

(This section to be completed by the office of the Administrator of the institution or program wherein the applicant satisfactorily completed (or will complete) a program approved post-graduate training in the United States or Canada)

This is to certify that William O. Ramos , M.D. undertook and
(Name of Applicant in Full)

satisfactorily completed a full term approved program of 12 months in the: Office of Chief Medical Examiner
(Number) (Full Name and Complete Address of Hospital)

of the City of New York

in the field of Forensic Pathology from 7/1/90 to 6/30/91
(Date) (Date/Anticipated Date)

and that the said program was approved for post-graduate training during that period by the Accreditation Council for Graduate Medical Education, or the Royal College of Physicians and Surgeons of Canada. YES X NO _____

1. Was applicant ever required to repeat any segment of training? NO If YES, which part(s)? _____

2. Was applicant ever placed on probation, restricted or limited? NO If YES, please attach a written explanation.

3 Was there any reason not to continue applicant in the training program? NO If YES, please attach a written explanation.

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TUMBLE

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If "YES" to any part of this question, please provide details on a Supplemental Form.

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7. Were applicant's final evaluations in every category rated satisfactory and/or above? YES If NO, please attach certified photocopy of evaluation, together with written explanation.

Signed Charles S. Hirsch, M.D.

(SEAL OF HOSPITAL)
(So indicate if none)

Title Chief Medical Examiner

Address: 520 First Avenue New York, NY 10016 Date 12 May, 1995

Revised 2/95 Reorder # IPS 40169

The applicant must assume the responsibility for completion of this form and is forewarned that it must be fully completed and forwarded to the Arizona Board of Medical Examiners before any application may be considered.

CITY OF NEW YORK

OFFICE OF CHIEF MEDICAL EXAMINER

This Certifies That

WILLIAM RAMOS, M.D.

Has Satisfactorily Served As

FELLOW IN FORENSIC PATHOLOGY

During the Twelve Months Ending the Thirtieth Day of June, 1991

Chief Medical Examiner

First Deputy Chief Medical Examiner

NATIONAL BOARD OF MEDICAL EXAMINERS®

ENDORSEMENT OF CERTIFICATION

ela Chung, Christopher Kung

Note: **The embossed seal of the National Board of Medical Examiners (NBME®) in the lower left corner certifies the authenticity of this document.**

Diplomate Name: William Douglas Ramos, MD

Date of Birth: [redacted]

Certification Date: 07/01/1971 **Certificate #:** 109668

It is certified that the physician named above has successfully completed the examination, education, and training requirements for certification by the NBME as of the certification date shown above.

Exam	Test Date	Total Test	Min. Pass	Pass/ Fail	Anat	Phys	Bioc	Path	Micr	Phar	Beh Sci
NBME PART I	Jun 1968	84	75	PASS	85	88	85	81	77	88	
					Med	**Surg**	**Ob/Gyn**	**PM/PH**	**Ped**	**Psych**	
NBME PART II	Apr 1970	82	75	PASS	84	81	88	87	76	76	
NBME PART III	Mar 1971	85.7	75	PASS							

DATE: 05/30/1995

SEE OTHER SIDE FOR SCORE INFORMATION

RECEIVED B.O.M.E.X. AZ0915

JUN -2 95

This [illegible] *Certification* may include scores for Step 1, Step 2, or Step 3 of the United States Medical Licensing Examination™ (USMLE™). The USMLE, established by the Federation of State Medical Boards (FSMB) and the NBME, is a single unified medical licensure examination system comprised of three Step examinations. USMLE replaced both the Federation Licensing Examination (FLEX) and the NBME Parts I, II and III. The NBME accepts passing scores on Part I or Step 1, plus Part II or Step 2, plus Part III or Step 3 as meeting the examination requirements for its certification program. Physicians who have passed at least one NBME Part in combination with one or two USMLE Steps will be certified and endorsed to medical licensing authorities by the NBME. Scores of physicians who pass Steps 1, 2 and 3 will be reported by the FSMB.

INTERPRETATION OF SCORES

NBME Part I and Part II Examinations Prior to June 1991

The most recent total test and subject scores are reported. The total test score is based on the total number of questions answered correctly on the entire examination and is not the average of the subject scores. There are no minimum pass requirements for individual subjects within a Part. Scores are on a three-digit scale with a mean of 500 and a standard deviation of 100 in increments of 5.

NBME Part I and Part II Examinations June 1991 and Thereafter

The most recent total test score is reported. This score is on the Step 1 or Step 2 scale with a mean of 200 and a standard deviation of 20 in increments of 1.

USMLE Step 1, Step 2, and Step 3

Cumulative USMLE examination history is given. A total test score is reported on a three digit scale with a mean of 200 and a standard deviation of 20 in increments of 1.

All NBME Part III Examinations

The most recent total test score is reported. This score is on the 3 digit scale with a mean of 500 and a standard deviation of 100 in increments of 5.

Two-Digit Scores

For all examinations, a two-digit equivalent value scale score on a two-digit scale is also provided. The scale score mean is 82 and the minimum pass total scale score is 75. Scale scores are reported in increments of 1.

EXPLANATION OF COMMENTS

For USMLE Steps, this document is annotated to reflect special circumstances regarding the score report.

If you wish to obtain further information about individual examinees who have notations under "Comments," please write the NBME Department of Licensing Examination Services Examinee Records Unit.

Indeterminate - Results that cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. Decisions to classify results as indeterminate may be made on the basis of factors that include, but are not limited to, inconsistency of performance within the examination or between administrations within the same Step. **No score is reported.**

Incomplete - The examinee sat for some but not all of the scheduled test books. **No score is reported.**

Irregular Behavior - The USMLE Committee on Irregular Behavior determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. To determine the exact nature of the irregular behavior, the examinee's full record of the deliberations and determination of the Committee on Irregular Behavior can be requested by contacting the USMLE Secretariat at (215) 590-9600.

Score Not Available - Score not available pending further review and/or analysis.

Testing Accommodations - Following review and approval of a request from the examinee, testing accommodations were provided in the administration of the examination.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

SATISFACTION OF REQUIREMENTS SUMMARY

BOARD ENDORSEMENT

APPLICATION Received May 9, 1995

NAME IN FULL RAMOS (Last) WILLIAM (First) DOUGLAS (Middle)

Current Address [redacted]

Telephone [redacted] (Residence) (718) 548-8151 (Office)

BIRTHPLACE [redacted] (City) (State) (Country) **Date:** [redacted]

CITIZENSHIP **Check One:** ☒ Native ☐ Naturalized **Declared Intention On**

MEDICAL EDUCATION

035-08
State University of New York Downstate Medical Center College of Medicine, Brooklyn NY
(Full Name and Location of Medical School)

M.D. Awarded: June 3, 1970 **Proof Received:** ☒ Approved

ECFMG Certificate No. N/A **Dated:** **Proof Received:**

POSTGRADUATE TRAINING

Form III/ photos — **In** OBG (Field of Training) **for** 54 **months at** State University Kings County Hospital Center Brooklyn, NY (Name of Institution)
From July 1, 1970 **to** December 31, 1974

Form III — **In** PTH (Field of Training) **for** 48 **months at** Darthmouth-Hitchcock Medical Center Lebanon, NH (Name of Institution)
From July 1, 1986 **to** June 30, 1990

Form III/ photo — **In** FOP (fellowship) (Field of Training) **for** 12 **months at** City of New York Office of Chief Medical Examiners, New York, NY (Name of Institution)
From July 1, 1990 **to** June 30, 1991

In (Field of Training) **for** **months at** (Name of Institution)
From **to**

In (Field of Training) **for** **months at** (Name of Institution)
From **to**

AMERICAN BOARD

Of PTH (50) OBG (30) **Certificate No.** 90-124 **Issued** August 30, 1990 November 5, 1976

Of FOP (50) sub(Specialty) **Certificate No.** SQ-91-032 **Issued** June 4, 1991

photos (Specialty) verification of PTH 8/17/95 verification of OBG 7/27/95

PRACTICE **Field of** OBG / PTH (Current)

LICENSES

	SPEX EXAM:	DATE:	SCORE:	PROOF REC'D
Form II	Endorsement through National Board (Certificate)	; No. 109668	; Issued 7/1/71 (Date)	W/E
	Nevada, #3597, 6/3/78	; [ ] W/E	[ ] FLEX	[x] Recip. With National Board
	In New York, #108816, 7/1/71	; [ ] W/E	[ ] FLEX	[x] Recip. With National Board
	In Vermont, #42-000-7546, 4/15/87	; [ ] W/E	[ ] FLEX	[x] Recip. With National Board
	In California, #G28860, 2/7/75	; [ ] W/E	[ ] FLEX	[x] Recip. With National Board
	In New Hampshire, #7527, 3/4/87	; [ ] W/E	[ ] FLEX	[x] Recip. With National Board
	In	; [ ] W/E	[ ] FLEX	[ ] Recip. With
	In	; [ ] W/E	[ ] FLEX	[ ] Recip. With
	In	; [ ] W/E	[ ] FLEX	[ ] Recip. With
	In	; [ ] W/E	[ ] FLEX	[ ] Recip. With

(TUMBLE)

con't W. D. Ramos, M.D.

U.S. MILITARY OR PUBLIC HEALTH SERVICE	**Served in** US Air Force	**From** January 11, 1967	**to** June 29, 1978
	Honorable Discharge Received (Branch) June 29, 1978	**Discharge Rank** Major	
PREVIOUS PRACTICE	In Brooklyn (internship/residency) NY	From July 1, 1970	to Dec. 31, 19 74
	In USAF	From January 11, 1967	to June 30, 19 78
	In Reno, NV	From July 1978	to June 19 86
	In Lebanon (residency) New Hampshire	From July 1, 1986	to June 30, 19 90
	In New York (fellowship) NY	From July 1, 1986	to June 30, 19 91
	In New York, NY	From July 1991	to Date 19 95
	In	From 19	to 19
	In	From 19	to 19
	In	From 19	to 19
	In	From 19	to 19
	In	From 19	to 19
	In	From 19	to 19
	In	From 19	to 19
	In	From 19	to 19

FEES	**Temporary $**	**Receipt #**	**Examination $**	**Receipt #**	
	Locum Tenens $	**Receipt #**	Board **Endorsement $** 450.00	**Receipt #**	A067765

INVESTIGATION	**AMA Approval**	5/30/95, Record Clear, N/D
	Nevada **Board Approval**	6/19/95, Cert. #3597, iss. 6/3/78, End., nonrenewed, N/D
	New York **Board Approval**	6/16/95, Cert. #108816, iss. 7/1/71, End., current, N/D
	Vermont **Board Approval**	5/30/95, Cert. #42-0007546, iss. 4/15/87, End., nonrenewed, N/D
	California **Board Approval**	5/18/95, Cert. #G28860, iss. 2/7/75, End., nonrenewed, N/D
	New Hampshire **Board Approval**	5/15/95, Cert. #7527, iss. 3/4/87, End., nonrenewed, N/D
	Fed. State **Board Approval**	5/17/95, Record Clear, N/D
	Board Approval	
	Board Approval	
	Board Approval	
	Board Approval	
	Ass'n Approval	
	Ass'n Approval	
	Ass'n Approval	
INTENDED LOCATION	Phoenix, Glendale, Scottsdale	

cg 9/1/95 11/14/95

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

1651 E. Morten Avenue, Suite 210, Phoenix, AZ 85020

KINDLY COMPLETE AND SEND TO THE FEDERATION OF STATE MEDICAL BOARDS AT THE ADDRESS BELOW.

DATE: 4/28/95

Coordinator, Disciplinary Data Bank
Federation of State Medical Boards
400 Fuller Wiser Rd.
Euless, TX 76039

The ARIZONA BOARD OF MEDICAL EXAMINERS requests a disciplinary search concerning the following individual:

NAME: RAMOS (LAST) William (FIRST) DOUGLAS (MIDDLE)

ADDRESS: [redacted]

City, State and Zip [redacted]

Date of Birth [redacted]

MAY 0 9 1995

Social Security Number [redacted]

STATE U. OF NEW YORK, DOWNSTATE BROOKLYN, NY
Medical School of Graduation and Branch Location

6/3/70
Date of Graduation

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

MAY 16 1995

James R. Winn, M.D.
JAMES R WINN, M D
EXECUTIVE VICE-PRESIDENT

Please mail the response to the following:

Arizona Board of Medical Examiners
1651 East Morten Avenue, Suite 210
Phoenix, Arizona 85020

William O. Ramos M.D.
Signature

BOMEX

MAY 17 1995

THIS IS AN IMPORTANT RECORD
SAFEGUARD IT

1 LAST NAME-FIRST NAME-MIDDLE NAME	2 SEX	3 SOCIAL SECURITY NUMBER	4 DATE OF BIRTH	YEAR	MONTH	DAY
RAMOS WILLIAM DOUGLAS	M	[redacted]		[redacted]		

5 DEPARTMENT COMPONENT AND BRANCH OR CLASS	6a GRADE RATE OR RANK	b PAY GRADE	7 DATE OF RANK	YEAR	MONTH	DAY
RegAF (MC)	*MAJ	0-4		1972	Dec	11

8a SELECTIVE SERVICE NUMBER	b SELECTIVE SERVICE LOCAL BOARD NUMBER CITY STATE AND ZIP CODE	c HOME OF RECORD AT TIME OF ENTRY INTO ACTIVE SERVICE (Street RFD City State and Zip Code)
NA	NA	[redacted]

9a TYPE OF SEPARATION	b STATION OR INSTALLATION AT WHICH EFFECTED
Discharge	Vandenberg AFB, CA

c AUTHORITY AND REASON	d EFFECTIVE DATE	YEAR	MONTH	DAY
----------		1978	Jun	29

e CHARACTER OF SERVICE	f TYPE OF CERTIFICATE ISSUED	10 REENLISTMENT CODE
HONORABLE	DD Form 256AF	----------

11 LAST DUTY ASSIGNMENT AND MAJOR COMMAND	12 COMMAND TO WHICH TRANSFERRED
USAF Hospital, Vandenberg (SAC)	NA

13 TERMINAL DATE OF RESERVE/MSS OBLIGATION YEAR	MONTH	DAY	14 PLACE OF ENTRY INTO CURRENT ACTIVE SERVICE (City State and Zip Code)	15 DATE ENTERED ACTIVE DUTY THIS PERIOD YEAR	MONTH	DAY
NA			New York, NY 10463	1967	Jan	11

16a PRIMARY SPECIALTY NUMBER AND TITLE	b RELATED CIVILIAN OCCUPATION AND D O T NUMBER
9496-Obstetrician & Gynecologist	Obstetrician 070.108

17a SECONDARY SPECIALTY NUMBER AND TITLE	b RELATED CIVILIAN OCCUPATION AND D O T NUMBER
NA	NA

18 RECORD OF SERVICE	YEARS	MONTHS	DAYS
a NET ACTIVE SERVICE THIS PERIOD	11	05	19
b PRIOR ACTIVE SERVICE	00	00	00
c TOTAL ACTIVE SERVICE (a+b)	11	05	19
d PRIOR INACTIVE SERVICE	00	10	07
e TOTAL SERVICE FOR PAY (c+d)	12	03	26
f FOREIGN AND/OR SEA SERVICE THIS PERIOD	00	00	00

19 INDOCHINA OR KOREA SERVICE SINCE AUGUST 5 1964	20 HIGHEST EDUCATION LEVEL SUCCESSFULLY COMPLETED (In Years)
☐ YES ☒ NO	SECONDARY/HIGH SCHOOL 12 YRS (If 12 grades) COLLEGE 8 YRS

21 TIME LOST (Preceding Two Yrs)	22 DAYS ACCRUED LEAVE PAID	23 SERVICEMEN'S GROUP LIFE INSURANCE COVERAGE	24 DISABILITY SEVERANCE PAY	25 PERSONNEL SECURITY INVESTIGATION a TYPE	b DATE COMPLETED
NO TIME LOST	1.0	☐ $15 000 ☐ $5 000 (X) #20,000 ☐ $10 000 ☐ NONE	☒ NO ☐ YES AMOUNT NA	*BI	20 Jan 65

26 DECORATIONS MEDALS BADGES COMMENDATIONS CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED

AFOUA W/1OLC, AFR 900-48. SAEMR W/1 Device, AFR 900-48. NDSM, AFR 900-48. AFLSA, AFR 900-48.

27 REMARKS

Blood Group: [redacted] AFSN: AF11430656 DAFSC: 9496.
*Item 25a cont: 1st Dist/OSI Westover AFB, MA 01022.

"Individual requests a copy of DD Form 214." WPR

28 MAILING ADDRESS AFTER SEPARATION (Street RFD City County State and Zip Code)	29 SIGNATURE OF PERSON BEING SEPARATED
[redacted]	William D. Ramos M.D.

30 TYPED NAME GRADE AND TITLE OF AUTHORIZING OFFICER	31 SIGNATURE OF OFFICER AUTHORIZED TO SIGN
JAMES FREDERICK JR, 2LT, USAF Chief, Quality Force Section	James Frederick Jr.

DD FORM 1 NOV 72 214

THIS IS AN IMPORTANT RECORD
SAFEGUARD IT

REPORT OF SEPARATION FROM ACTIVE DUTY

REQUEST TO CONVERT LIMITED LICENSE TO UNRESTRICTED MEDICAL LICENSE

I, **William Douglas Ramos, M.D.** request that the Arizona Board of Medical Examiners convert my "Limited License" to practice medicine in my designated medical specialty to an unrestricted license to practice medicine.

5/6/99 — Date

William D. Ramos M.D. — Signature

NOTICE OF REFUSAL TO REQUEST UNRESTRICTED MEDICAL LICENSE

I, **William Douglas Ramos, M.D.** decline to request an unrestricted Board license. I understand that, as a result of my decision to refuse conversion of my limited license to an active unrestricted Board license, the Board may institute formal administrative proceedings to rescind, revoke or void any limited license for 1998 or 1999 previously issued by the Board to me, if I do not voluntarily surrender limited licensure.

Date

Signature

INSTRUCTIONS: Mail or deliver this form, after reading and signing, to **Arizona State Board of Medical Examiners - Attention: Licensing Section, 1651 E. Morten, Suite 210, Phoenix, Arizona 85020**

Is your RETURN ADDRESS completed on the reverse side?

SENDER:

- Complete items 1 and/or 2 for additional services
- Complete items 3, 4a, and 4b
- Print your name and address on the reverse of this form so that we can return this card to you
- Attach this form to the front of the mailpiece, or on the back if space does not permit
- Write *"Return Receipt Requested"* on the mailpiece below the article number
- The Return Receipt will show to whom the article was delivered and the date delivered

I also wish to receive the following services (for an extra fee)

1 ☐ Addressee's Address
2 ☐ Restricted Delivery

Consult postmaster for fee

3 Article Addressed to

William Douglas Ramos, M.D.
1670 E Flamingo Rd., Ste C
Las Vegas, NV 89119

4a Article Number
Z 469 233 246

4b Service Type
☐ Registered ☒ Certified
☐ Express Mail ☐ Insured
☐ Return Receipt for Merchandise ☐ COD

7 Date of Delivery
5-27-99

5 Received By *(Print Name)*

8 Addressee's Address *(Only if requested and fee is paid)*

6 Signature *(Addressee or Agent)*
X D Christy

PS Form **3811**, December 1994 102595-98-B-0229 Domestic Return Receipt

Thank you for using Return Receipt Service

Arizona State Board of Medical Examiners
1651 East Morten, Suite 210 Phoenix, Arizona 85020
Phone (602) 255-3751 Fax (602) 255-1848
Home Page: http://www.docboard.org

April 30, 1999

William Douglas Ramos, M.D.
1670 E. Flamingo Rd., Ste. C
Las Vegas, NV 89119-0000

Re: Physicians Holding Limited License to Practice Medicine; Statutory Revision of Board Authority

Dear Dr. Ramos:

On April 26, 1999, Governor Jane Dee Hull signed Senate Bill (S.B.) 1091 into law and it became effective immediately. S.B. 1091 in part authorizes the Board to convert Board licenses of physicians, that were previously held or received in calendar year 1998, and that restricted medical practice to a designated area of medical specialization (i.e., "limited licenses"), to active unrestricted Board licenses to practice medicine in the State of Arizona.

The Board's licensing records reflect that you held or were authorized by the Board to receive a limited license in 1998. Pursuant to S B. 1091, before the Board may issue you a new unrestricted Board license, a request must be received by the Board from a qualified physician to convert the limited license to an unrestricted Board license.

If you wish to request unrestricted licensure to practice medicine in Arizona, sign the attached form where designated and return the form by mail or personal delivery to the Board's office. Upon receipt of your request, staff will promptly process your request for unrestricted active license. Please note that S.B. 1091 mandates that the request to convert to unrestricted Board license must be made within 120 days from the effective date of S.B. 1091, i.e., April 26, 1999.

If you are currently practicing medicine in Arizona, pursuant to 1998 or 1999 limited license, you should promptly submit your request to convert to an active unrestricted license to avoid any legal ambiguity over your ability to lawfully continue practicing medicine in the State of Arizona. Limited licenses to practice medicine, that are not converted to active unrestricted licenses, shall be subject to administrative action by the Board for revocation or nullification of those limited licenses, after expiration of the aforementioned 120 day time period. If you do not intend to convert your limited license to an unrestricted license, please sign, date and return the attached form as provided.

Thank you for your patience and cooperation while the Board and the Legislature resolved this difficult issue arising out of the expiration of the Board's previous statutory authority to issue limited licenses. Please call the Board if you have any questions at (602) 255-3751 ext. 7800

Sincerely,

Claudia Foutz

Claudia Foutz, Executive Director

Enclosure

Arizona State Board of Medical Examiners
1651 East Morten, Suite 210 Phoenix, Arizona 85020
Telephone (602) 255-3751 Fax (602) 255-1848
Home Page. http //www docboard.org

Certified Mail/Return Receipt Requested
No. Z434973110

January 26, 1999

William Douglas Ramos, M.D.
1670 E. Flamingo Rd., Ste. C
Las Vegas, NV 89119-0000

Re: Notice of Nullification of all 1999 Limited Licenses to Practice Medicine in Arizona issued by BOMEX

Dear Doctor Ramos:

INTRODUCTION

This letter is sent to advise you of a significant change in the statute that previously authorized the State Board of Medical Examiners (hereafter, "BOMEX") to issue a special license to practice medicine which limited a physician to his or her certified area of medical specialty. See, Arizona Revised Statutes ("A.R.S") § 32-1426(C), as amended and effective in 1995 until expiration on November 1, 1998. BOMEX physician licensure records reflect that you were sent a 1999 license that limited your right to practice medicine in Arizona solely for your certified area of medical specialization.[1]

Effective as of November 1, 1998, and pursuant to amendment of state statute A.R.S. § 32-1426(C), BOMEX's authority to issue licenses to physicians that limit the practice of medicine in Arizona to a certified medical specialty expired. Additionally, the statute did not authorize existing BOMEX physicians, with limited licenses to practice a medical specialty (referred to hereafter as "limited licenses"), to be "grandfathered" or converted to regular unrestricted BOMEX physician licensure. Therefore, BOMEX may not legally renew any pre-existing limited medical practice license for 1999 or issue new limited licenses to new applicants for 1999. An agency of the State may only exercise that authority and power as provided by Arizona Constitution or statute. BOMEX may only

[1] If this is not a correct statement of your licensure status with BOMEX, please promptly send a letter, to the address appearing at the end of this letter advising this agency of what you believe is your correct licensure status and enclose a photocopy of last BOMEX license identity card received by you

Is your RETURN ADDRESS completed on the reverse side?

SENDER:

- Complete items 1 and/or 2 for additional services.
- Complete items 3, 4a, and 4b
- Print your name and address on the reverse of this form so that we can return this card to you.
- Attach this form to the front of the mailpiece, or on the back if space does not permit
- Write *"Return Receipt Requested"* on the mailpiece below the article number.
- The Return Receipt will show to whom the article was delivered and the date delivered

I also wish to receive the following services (for an extra fee):

1. ☐ Addressee's Address
2. ☐ Restricted Delivery

Consult postmaster for fee.

3. Article Addressed to:

WILLIAM DOUGLAS RAMOS, M D
1670 E FLAMINGO RD , STE C
LAS VEGAS, NV 89119-0000

4a. Article Number

Z 434 973 110

4b. Service Type

- ☐ Registered
- ☒ Certified
- ☐ Express Mail
- ☐ Insured
- ☐ Return Receipt for Merchandise
- ☐ COD

7. Date of Delivery

1-28-99

5. Received By: *(Print Name)*

8. Addressee's Address *(Only if requested and fee is paid)*

6. Signature: *(Addressee or Agent)*

X J. ROONEY

PS Form **3811,** December 1994 102595-98-B-0229 Domestic Return Receipt

Thank you for using Return Receipt Service.

issue and renew licenses to practice medicine to those individuals who qualify for licensure pursuant to current and effective statutes and administrative regulations. See, Kendall v. Malcolm, 98 Ariz. 329, 334, 404 P.2d 414, 417 (1965); and, Boyce v. City of Scottsdale, 157 Ariz. 265, 267, 756 P.2d 934, 936 (App. 1988). If an agency of the State takes action that is beyond its legal authority, the action is void. See, Magma Copper Co. v. Arizona State Tax Commission, 67 Ariz. 77, 86-87, 191 P.2d 169, 175 (1948).

BOMEX staff started sending notices to physicians for renewal of limited medical licenses for 1999 on October 30, 1998. Due to the aforementioned legal reasons, renewal of limited licenses should not have been processed by BOMEX staff for 1999. Therefore, a physician currently practicing medicine in Arizona solely pursuant 1999 limited license is doing so under the authority of a voidable BOMEX limited license. The practice of medicine by a person not lawfully licensed to practice by BOMEX or otherwise exempt from licensure pursuant to statute, is a Class (5) felony criminal offense. However, please read carefully the explanation of legal analysis provided at page 3, paragraph 3, regarding your conditional and limited legal right to continue practicing medicine pursuant to the limited license issued to you.

ALTERNATIVE COURSES OF ACTION AVAILABLE TO YOU

(1) If you want to obtain an unlimited BOMEX medical license to replace your voidable limited license, you will need to make application in the same manner as any new applicant. Specifically, see A.R.S. § 32-1422 through § 32-1428, which appear in the 1998-99 BOMEX medical directory at pages 18-21.

In many instances, physicians currently holding a BOMEX limited license may want to apply for a standard unlimited BOMEX license pursuant to BOMEX statute A.R.S. § 32-1426 (licensure by endorsement). However, you should carefully review the requirements of A.R.S. § 32-1426 and specifically the requirements of A.R.S. § 32-1426(C) (as effective from November 1, 1998) which specifies that BOMEX licensure by endorsement can not be based on passage of a prior written examination or combination of examinations that pre-dates your new application by ten (10) years. In other words, applicants for licensure by endorsement whose passing examination scores for those examinations listed at A.R.S. § 32-1426(A)(1) and (2) are more than ten (10) years old, as of the date of application to BOMEX, must take and pass the "special purpose licensing examination" (SPEX) with a score of at least 75%, pursuant to A.R.S. § 32-1426(C) and § 32-1401(18)(b).[2]

Physicians who do not meet the criteria for standard BOMEX licensure by endorsement will have to satisfy the licensure by examination requirements at A.R.S. § 32-1425.

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[2] Please consult your BOMEX "Medical Directory" for 1998-99 to review the aforementioned statutes in their entirety which appear in the yellow pages of the directory, pages 11-32

(2) Pursuant to A.R.S. § 32-1428, the BOMEX executive director may issue to qualified applicants a temporary license to practice medicine; but the temporary license may only be issued to an applicant seeking licensure by endorsement whose application is complete except for taking and passing the SPEX examination as required by A.R.S. § 32-1426(C). Before issuing a temporary license under this statute, the applicant must:

> (1) submit a completed BOMEX application for licensure by endorsement and expressly request a temporary license; and, (2) pay all required fees; and, (3) provide proof of registration for the SPEX with a definite date for taking the SPEX.

Note that the temporary license expires on the last day of the month in which the SPEX grades of the applicant are reported to BOMEX and may not be extended, pursuant to A.R.S. § 32-1428(B), (C). The applicant for a temporary license must take the SPEX examination within the time period established by the administrator of the SPEX, i.e., Federation of State Medical Boards. Currently physicians registered for the SPEX are required by the SPEX administrator to take the examination within 90 days from date of notification from the SPEX administrator that registration was approved.

If the applicant receives a temporary license and does not take the SPEX examination within the aforementioned time period, the temporary license shall expire at the end of the month when the SPEX examinations scores are reported, for the last month wherein the applicant could have taken the examination, as required by A.R.S. § 32-1428(C). Pursuant to A.R.S. § 32-1428(C), the temporary license may not be extended beyond the previously described time period.

(3) Pursuant to the Administrative Procedures Act at A.R.S. § 41-1092.11(B), when a State agency determines that a license issued by the agency is null and void, *the decision of the State agency (i.e., BOMEX) is not effective and final until the State agency "... provides the licensee with notice and an opportunity for a hearing."*

A physician holding a voidable BOMEX 1999 limited license will in the future receive from BOMEX notice of a specific date, time and location of the hearing at which the physician may contest BOMEX's decision as reported in this letter. Said notice will be served on the physician at least thirty (30) days before the hearing, pursuant to A.R.S. § 41-1092.05(D). In the event that a limited licensee physician fails to enter a written response or appearance at said hearing, the Board's decision in regard to the voiding of the physician's limited license shall become final and not appealable. See, Rosen v. Board of Medical Examiners, 185 Ariz. 139, 912 P.2d 1368 (App. 1995).

In other words, this matter will be treated as a contested case pursuant to A.R.S. § 41-1092.05(A)(2); and, the case will either be scheduled for hearing before the Board or referred to the Office of Administrative Hearings to conduct the hearing. Pursuant to A.R.S. § 41-1092.11, BOMEX's notification to you by this letter of the nullification of

1999 limited licensure shall not be final and effective until after the conclusion of the administrative hearing process. Therefore, while this matter is pending final conclusion of the administrative hearing process it is the policy of BOMEX that a limited licensee physician may continue to practice medicine in Arizona within the limits of his or her area of medical specialization, pending final disposition of the physician's specific contested case.

(4) Physicians holding 1999 limited licenses may elect to follow simultaneously alternative (3), in conjunction with either alternatives (1) or (2). However, if you wish to obtain a new unlimited standard BOMEX license, you should act promptly. See the attached form for review and completion by you, if you want to apply for BOMEX's standard unlimited physician license.

CONCLUSION

The Board's policy as described above in regard to the termination of its authority to issue limited licenses to practice in a certified area of medical specialization is dictated not only by the language of the Board's statutes but by recent Arizona appellate court case law. Specifically, in the case of Hansson v. Arizona State Board of Dental Examiners, reported at 283 Ariz. Adv. Rpt. 29 (Ariz. Court of Appeals, Division One, Opinion issued 12/3/98), the Arizona Court of Appeals held that because of the expiration and repeal of a statute authorizing the Board of Dental Examiners to issue licenses for the limited practice of dentistry (i.e., designated area of specialization), the Dental Board was prohibited from renewing Dr. Hansson's pre-existing limited Dental Board license. On advice of the Office of the Arizona Attorney General, it has been decided that the legal analysis by the Court of Appeals in the Hansson decision also supports BOMEX's conclusion regarding the expiration of BOMEX's authority to issue limited licenses pursuant to A.R.S. § 32-1426(C)(i.e., authorizing limited licensure for area of medical specialization).

On January 13, 1999, the members of the Board of Medical Examiners conducted a special public meeting regarding this topic. At the meeting the Board received legal advice and considered alternative solutions to this problem. The Board members unanimously authorized issuance of this letter. Furthermore, the Board voted to authorize the Chairman and Executive Director to initiate communication with Legislative leadership to explore obtaining legislation to remedy this legal problem. You will be advised if progress is made in that regard.

In closing, please be advised that the expiration of the Board's authority to issue limited medical specialty licenses on November 1, 1998, occurred pursuant to the mandate of the Legislature which originally created this special licensing authority in 1995. In other words, the Board and its Executive Director did not initiate this statutory change and deletion of the Board's authority to issue limited licenses for medical practice. Nevertheless, on behalf of the Board and BOMEX staff, we wish to apologize for not

advising physicians holding limited medical practice licenses sooner of the implications of the change in the Board's statutory authority.[3]

The legal opinions expressed within this letter reflect the position of the Board and its legal counsel; and therefore, you may wish to seek the advice of legal counsel before making a final decision regarding the alternatives available to you. Correspondence from you to BOMEX concerning this topic should be directed to:

Arizona Board of Medical Examiners
Licensing Section/Limited Licenses
1651 E. Morten, Suite 210
Phoenix, Arizona 85020

Sincerely,

Claudia Foutz

Claudia Foutz
Executive Director

Enclosure (BOMEX FORM)

[3] Please note that the BOMEX Medical Directory (sent to all BOMEX licensed physicians) for the years 1996-97, at pages 22-23, and 1997-98, at pages 24-25, reprinted A.R.S § 32-1426 (Licensure by endorsement) with an italicized notation stating that the statute would be effective as printed until November 2, 1998, and then reprinting the statute as amended and effective after that date. The intent in publishing the statute in this manner in the Medical Directory was to provide some notification to limited licensee physicians of the statutory change

Z 434 973 110

US Postal Service

Receipt for Certified Mail

No Insurance Coverage Provided

Do not use for International Mail *(See reverse)*

Sent to	
Street & Number	
Post Office, State, & ZIP Code	
Postage	$
Certified Fee	
Special Delivery Fee	
Restricted Delivery Fee	
Return Receipt Showing to Whom & Date Delivered	
Return Receipt Showing to Whom, Date, & Addressee's Address	
TOTAL Postage & Fees	$
Postmark or Date	

PS Form **3800**, April 1995

ARIZONA BOARD OF MEDICAL EXAMINERS

STIPULATION PURSUANT TO A.R.S §32-1426(C)

A.R.S. §32-1426(C) as amended 1995, states that an applicant for licensure by endorsement who is certified or recertified by a specialty board that is recognized by the American Board of Medical Specialties is exempt from the licensing examination required by A.R.S. §32-1426(C) provided that the applicant is currently a full-time instructor in an accredited residency teaching program or is in full time practice with current continuing medical education credits. A physician who is licensed under this exemption is required to stipulate to the Board of Medical Examiners that the physician shall not practice outside of that specialty.

Pursuant to A.R.S. §32-1426(C), the undersigned applicant stipulates to the Arizona Board of Medical Examiners that he/she is currently certified or recertified by the following Specialty Board that is recognized by the American Board of Medical Specialties:

American Board of Obstetrics And Gynecology
American Board of Pathology (Anatomic, Clinical and Forensic)

Name of Specialty Board Recognized by American Board of Medical Specialties

Obstetrics And Gynecology
Anatomic, Clinical, and Forecsic Pathology

Specialty

Obstetrics And Gynecology -- 11/5/76
Pathology, Anatomic and Clinical -- 8/30/90
Pathology, Forensic -- 6/4/91

Date of Certification or Recertification

Applicant stipulates that if applicant is granted a license pursuant to the exemption, applicant shall not practice medicine outside of the specialty stated above.

Applicant understands that violation of this stipulation may be grounds for disciplinary action, including revocation of license.

William D. Ramos, M.D.
Print Name of Applicant

William D. Ramos M.D.
Signature

July 17, 1995
Date

RECEIVED B.O.M.E.X.
JUL 20 95

ARIZONA BOARD OF MEDICAL EXAMINERS

November 17, 1995

William Douglas Ramos, MD
[redacted]

Dear Dr Douglas

Congratulations! Your certificate to practice medicine in the State of Arizona, License No 23599, issued on November 17, 1995, is enclosed with your wallet registration card for the current year

Please be advised that **annual re-registration is mandatory** on a calendar-year basis Arizona statutes provide that each licentiate renew registration on January 1st of every year To maintain a current license, you are required to pay an annual renewal fee Notification of renewal will be mailed to your address of record on or about November 1st of each year Failure to re-register will result in statutory expiration of your license It is your responsibility to keep the Board informed of address changes Arizona Revised Statutes §32-1435 (B) provides that

> "Each person holding a current license to practice medicine in this state shall promptly and in writing inform the Board of his current residence and office address and of each change in his residence and office address that may later occur "

Enclosed for your information is the section of the Arizona Medical Practice Act which pertains to Unprofessional Conduct It is the responsibility of all licentiates in practice in Arizona to report directly to the Board of Medical Examiners any misconduct, unprofessional conduct or medical incompetence on the part of your colleagues which may come to your attention According to A R S § 32-1451 (A), failure to do so is actionable against your license to practice You will receive a copy of the Arizona State Medical Directory published annually by the Board which contains the Arizona Medical Practice Act It is suggested that you familiarize yourself with such prior to establishing your practice in Arizona

In addition, included with this letter is information regarding Continuing Medical Education requirements and Prescription Form requirements

Please contact Becky Drew, Licensing Manager, Extension 7101, should you have any questions

Sincerely,

BOARD OF MEDICAL EXAMINERS STATE OF ARIZONA

Elaine Hugunin
Deputy Director

12/94

Enclosures

1651 East Morten, Suite 210 • Phoenix, Arizona 85020 • Telephone (602) 255-3751 • FAX (602) 255-1848

Is your RETURN ADDRESS completed on the reverse side?

SENDER: LICENSING

- Complete items 1 and/or 2 for additional services
- Complete items 3, and 4a & b
- Print your name and address on the reverse of this form so that we can return this card to you
- Attach this form to the front of the mailpiece, or on the back if space does not permit
- Write "Return Receipt Requested" on the mailpiece below the article number
- The Return Receipt will show to whom the article was delivered and the date delivered

I also wish to receive the following services (for an extra fee)

1 ☐ Addressee's Address

2 ☐ Restricted Delivery

Consult postmaster for fee

3 Article Addressed to

William D. Ramos, MD

[redacted]

4a Article Number

P876 365 180

4b Service Type

☐ Registered ☐ Insured

☐ Certified ☐ COD

☒ Express Mail ☐ Return Receipt for Merchandise

7 Date of Delivery

12/1/95

5 Signature (Addressee)

8 Addressee's Address (Only if requested and fee is paid)

6. Signature (Agent)

PS Form **3811**, December 1991 ☆U.S. GPO 1992—323-402 **DOMESTIC RETURN RECEIPT**

Thank you for using Return Receipt Service.

ARIZONA BOARD OF MEDICAL EXAMINERS

READ CAREFULLY - THIS CAN SAVE YOU MONEY

November 15, 1995

William Douglas Ramos, M D
[redacted]

Dear Dr Ramos

The Board of Medical Examiners, State of Arizona, is pleased to inform you that your application and credentials for a license to practice medicine in the State of Arizona has been approved.

Arizona Revised Statutes provide for an initial registration of each licentiate and the certificate of license may not be issued until this is in hand Please complete the enclosed card and return it to the Board of Medical Examiners, State of Arizona, 1651 E Morten Avenue, Suite 210, Phoenix, AZ 85020. In order for your license to be issued, this card must be received by Thursday of each week. Your license may then be issued the following day, Friday **YOU MUST NOT COMMENCE THE PRACTICE OF MEDICINE IN THE STATE OF ARIZONA UNTIL A LICENSE NUMBER HAS BEEN ISSUED TO YOU**

Please note that the Arizona Revised Statutes further provide that each licentiate is required to renew such registration on January 1st of each year If you want to save money and you are **not** planning to practice medicine in Arizona until **after January 1, 1996**, the enclosed card can be submitted now **with your written instructions to withhold issuance of a license until after January 1, 1996** No license number will be assigned until the actual issuance of the license

The Board publishes an annual directory of all licentiates in this State, which is distributed around October of each year Information for this publication is taken from the registration card which you complete Home addresses and telephone numbers are **not** published, **unless this is the only address which you provide to the Board** The deadline for receipt of address changes for inclusion in this directory is **July 31st** of each year If you anticipate a move before that date, please indicate your new address(es) with the effective date as well as your current address(es)

1651 East Morten, Suite 210 • Phoenix, Arizona 85020 • Telephone (602) 255-3751 • FAX (602) 255-1848

[approval ltr]

ARIZONA BOARD OF MEDICAL EXAMINERS

Any questions you have regarding this communication may be directed to me, at Ext 7104 Thank you for your cooperation

Sincerely,

BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA

Maria Velasquez
Licensing Technician

Enclosures Also enclosed receipt #A067765 covering licensure fees

1651 East Morten, Suite 210 • Phoenix, Arizona 85020 • Telephone (602) 255-3751 • FAX (602) 255-1848

[approval]

ARIZONA BOARD OF MEDICAL EXAMINERS

ARIZONA BOARD OF MEDICAL EXAMINERS

November 14, 1995

TO: File of William Douglas Ramos, M.D.

FROM: Maria Velasquez

RE: **Hospital Affiliation**

Per conversation this afternoon with Denise at Elmhurst Hospital, she stated that Dr. Ramos did not have privileges at the Hospital, and there was no information available.

MV:mv

[/MEMO.01]

1651 East Morten, Suite 210 • Phoenix, Arizona 85020 • Telephone (602) 255-3751 • FAX (602) 255-1848

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

1651 East Morten Avenue, Suite 210, Phoenix, Arizona 85020, (602) 255-3751

September 19, 1995

William Douglas Ramos, M.D.
[redacted]

Dear Dr. Ramos:

Enclosed please find your personal check in the amount of four-hundred and fifty dollars. Unfortunately, we do not accept personal checks.

✓ Please re-submit the fee in the form of a Cashiers check or money order. 9/29/95

Thank you for your cooperation.

Sincerely,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Maria Velasquez
Licensing Technician

MV mv

Enc.1

Is your RETURN ADDRESS completed on the reverse side?

SENDER: LICENSING

- Complete items 1 and/or 2 for additional services
- Complete items 3, 4a, and 4b
- Print your name and address on the reverse of this form so that we can return this card to you
- Attach this form to the front of the mailpiece, or on the back if space does not permit
- Write *"Return Receipt Requested"* on the mailpiece below the article number
- The Return Receipt will show to whom the article was delivered and the date delivered

I also wish to receive the following services (for an extra fee):

1. ☐ Addressee's Address
2. ☐ Restricted Delivery

Consult postmaster for fee

3 Article Addressed to

William Douglas Ramos, M.D.

[redacted]

4a. Article Number

Z 346 106 229

4b Service Type

☐ Registered ☒ Certified
☐ Express Mail ☐ Insured
☐ Return Receipt for Merchandise ☐ COD

7. Date of Delivery

9/22 WM

5. Received By: *(Print Name)*

8 Addressee's Address *(Only if requested and fee is paid)*

6. Signature *(Addressee or Agent)*

X Heather Ramos

PS Form **3811**, December 1994 Domestic Return Receipt

Thank you for using Return Receipt Service.

William D. Ramos, M. D., FCAP

[redacted]

Diplomate, American Board of Obstetrics and Gynecology

Diplomate, American Board of Pathology
(Anatomical, Clinical and Forensic Pathology)

Mon, Sep 11, 1995

Board of Medical Examiners
State of Arizona
1651 East Morten Avenue
Phoenix, Arizona 85020

Dear Sirs:

Per my phone conversation today, the Registrar's Office of the State University of New York , Health Sciences Center of Brooklyn has lost my transcript during a recent move. They are trying to reconstruct a new one, and in the meantime will send your Form I without a transcript. Also, I have requested that the Nevada State Board of Medical Examiners send you a copy of their copy of my transcript that they received in March 1995. I hope that this is sufficient for your purposes.

I am also enclosing my check for the fee of $450.

Sincerely,

William Ramos M.D.

William D. Ramos, M. D.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

1651 East Morten Avenue, Suite 210, Phoenix, Arizona 85020, (602) 255-3751

September 7, 1995

William Douglas Ramos, MD
[redacted]

Dear Dr. Ramos

This will acknowledge receipt of your application for licensure to practice medicine in the State of Arizona through Endorsement

To complete processing of your application, the following information and/or documentation must be received by the Board.

The statutory fee of $450 00 9/29/95

Form I Medical College Certification from State University of New York Downstate Medical Center College of Medicine 10/5/95

Further, please be advised that applications not fully completed within one year from this date, including participation in written SPEX/USMLE Examination (if applicable), are considered withdrawn

Your application is being processed routinely and you will be advised as to the Board's decision relative to the granting of an Arizona license

If you have any questions regarding this communication, please contact me at Ext. 7102. Thank you for your cooperation

Sincerely,

BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA

Cindy Giesen
Licensing Technician

Enc:

/cg
/

[DEFICIEN LTR]

ARIZONA BOARD OF MEDICAL EXAMINERS

AFFIDAVIT

A.R.S. §32-1426(c)

STATE OF Vermont)

COUNTY OF Windsor)

I hereby certify that I am:
(check one)

☒ IN THE FULL-TIME PRACTICE OF MEDICINE AT THE FOLLOWING ADDRESS
Choices Women's Center, 97-77 Queens Blvd, Forest Hills, NY 11374
WITH CURRENT CONTINUING MEDICAL EDUCATION CREDITS

OR

☐ CURRENTLY A FULL-TIME INSTRUCTOR IN THE FOLLOWING _____
_____ ACCREDITED RESIDENCY TEACHING PROGRAM.
LOCATED AT _____
(Name of Institution)

Dated this 17th day of July, 19 95

William D. Ramos, M.D.
(Print or Type Full Name)

William Ramos M.D.
(Signature)

Sworn to before me this 17th day of July. 1995

Mary E Dill
(Notary Signature) [S E A L]

My Commission expires: 2/10/99

07/95

RECEIVED B.O.M.E.X.
JUL 20 95

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

1651 East Morten Avenue, Suite 210, Phoenix, Arizona 85020, (602) 255-3751

July 11, 1995

William Ramos, M D
[redacted]

Re Application for License through
Board Endorsement

Dear Doctor Ramos

Enclosed please find the three additional forms needed for your application for Licensure through Board Certification Verification of Specialty Board Certification, Affidavit verifying full-time practice with current continuing medical education credits or a full-time instructor in an accredited residency teaching program, and Stipulation stating that you are currently certified or recertified by a Specialty Board that is recognized by the American Board of Medical Specialties and will not practice outside the specialty stated

Please complete and return the Affidavit and Stipulation to this Board and forward the Verification of Specialty board certification to the appropriate board

If you have any questions please feel free to contact me at (602) 255-3751, extension 7103

Sincerely,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Marie Slaughter

Marie Slaughter
Examiner Technician

Enc 3

Nevada State Board of Medical Examiners

THIS IS TO CERTIFY THAT THE RECORDS OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS INDICATE THE FOLLOWING INFORMATION REGARDING:

RAMOS, William Douglas

LICENSE NUMBER	:3597
DATE ISSUED	:6/3/78
CURRENT STATUS	:SUSPENDED-Nonpayment of registration fees
EXPIRATION DATE	:7/2/87
MEDICAL SCHOOL	:State University of New York
DATE DEGREE RECEIVED	:6/3/70
EXAMINATION	:NATIONAL BOARDS
DISCIPLINARY ACTION	:NONE

DETAILS OF DISCIPLINARY ACTION WILL BE MADE AVAILABLE BY PHOTOCOPY FROM THE PUBLIC FILE UPON WRITTEN REQUEST ONLY.

TO EXPEDITE THE VERIFICATION OF LICENSURE/CERTIFICATION PROCESS, THE ABOVE IS THE STANDARD FORMAT FOR ALL PROFESSIONS REGULATED BY THIS BOARD.

Patricia R Perry

Patricia R. Perry, Executive Director

June 14, 1995

Date

We are not in a position to advise whether he/she is currently under investigation by the Board. Until such time as an investigation of any physician licensed by this Board is culminated by a formal complaint being filed, we are not in a position to reveal the facts or the nature of any ongoing investigation. We have, however, searched our records and do not find that any formal disciplinary action has been taken against this physician by our Board.

1105 Terminal Way, Suite 301 • (702) 688-2559 • Fax 688-2321
Mailing Address: Post Office Box 7238 • Reno, Nevada 89510

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
CUSTOMER SERVICE UNIT
CULTURAL EDUCATION CENTER
ALBANY, NEW YORK 12230

THIS IS TO CERTIFY THAT ACCORDING TO THE RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES, NEW YORK STATE EDUCATION DEPARTMENT, ALBANY, NEW YORK, RAMOS WILLIAM DOUGLAS
WAS ISSUED LICENSE/CERTIFICATE NUMBER 108816 FOR THE PRACTICE OF MEDICINE ON 07/01/71.

OUR RECORDS ALSO INDICATE THE FOLLOWING INFORMATION:
DATE OF BIRTH: [redacted]
SCHOOL ATTENDED: SUNY DOWNSTATE MED CTR
DATE OF GRADUATION: 06/03/70
DEGREE EARNED: MD

PROGRAM WAS ACCEPTABLE IN ACCORDANCE WITH THE NYS REGULATIONS OF THE COMMISSIONER OF EDUCATION. REQUIREMENTS MET AT THE TIME OF LICENSURE.

BASIS OF LICENSURE:
B NATIONAL BOARD CERT# 109668 DATED 07/01/71

A LICENSE IS VALID DURING THE LIFE OF THE HOLDER UNLESS REVOKED, ANNULLED OR SUSPENDED BY THE BOARD OF REGENTS. A LICENSEE MUST REGISTER PERIODICALLY WITH THIS DEPARTMENT TO PRACTICE IN THIS STATE

CURRENTLY REGISTERED: YES REG PERIOD ENDS: 08/31/96
ADDRESS: CHOICES WOMENS MEDICAL GROUP
97-77 QUEENS BLVD FOREST HILLS NY 11374-0000
DEROGATORY INFORMATION: NO CHARGES HAVE BEEN PREFERRED AGAINST THIS LICENSEE.
COMMENTS:

I FRANCES HARRIS, PRINCIPAL CLERK, DIVISION OF PROFESSIONAL LICENSING SERVICES OF THE NEW YORK STATE EDUCATION DEPARTMENT, DO HEREBY STATE THAT AS PRINCIPAL CLERK OF SAID DIVISION, I HAVE LEGAL CUSTODY OF THE OFFICIAL RECORDS OF THE DIVISION OF PROFESSIONAL LICENSING SERVICES AND TO THE BEST OF MY KNOWLEDGE, THE AFORESAID INFORMATION IS TRUE AND CORRECT.

SEAL

Frances Harris 06/07/95
PRINCIPAL CLERK

OP026 028

RECEIVED B.O.M.E.X.
JUN 16 95

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

VERIFICATION OF LICENSURE
THIS IS NOT AN ENDORSEMENT CERTIFICATION

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE MEDICINE. IF NEEDED,YOU MAY XEROX THIS FORM FOR ADDITIONAL COPIES.

DEAR SIR:

IN APPLYING FOR A LICENSE TO PRACTICE MEDICINE IN THE STATE OF ARIZONA, THE MEDICAL BOARD REQUIRES THIS FORM TO BE COMPLETED BY EACH STATE WHEREIN I HOLD OR HAVE EVER HELD LICENSURE. THIS IS YOUR AUTHORITY TO RELEASE ANY INFORMATION IN YOUR FILES, FAVORABLE OR OTHERWISE, DIRECT TO THE BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 1651 EAST MORTEN AVENUE,/SUITE 210, PHOENIX, ARIZONA 85020 YOUR EARLY RESPONSE IS APPRECIATED.

NAME: William DOUGLAS RAMOS .M.D.
(PLEASE PRINT)

ADDRESS [redacted]

MY LICENSE NUMBER IS: 7546

DO NOT DETACH

THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE ARIZONA BOARD OF MEDICAL EXAMINERS.

STATE OF: Vermont

FULL NAME OF LICENSEE: William Douglas Ramos, MD

GRADUATE OF University of New York

LICENSE NO : 42-000 7546 ISSUE DATE: 04/15/87

BY:ENDORSEMENT/RECIPROCITY WITH: National Boards

BY: YOUR STATE BOARD'S WRITTEN EXAMINATION/FLEX/SPEX/USMLE: National Boards

LICENSE IS CURRENT? _____ IF NO, WHY NOT? inactive per request 11/30/90

DEROGATORY INFORMATION, IF ANY: none

SIGNED: Janice E Lifield TITLE Staff Assistant

STATE BOARD: Vermont Board of Medical Practice

DATE: 5/24/95 [BOARD SEAL]

[PLEASE USE REVERSE SIDE FOR ADDITIONAL COMMENTS]

RECEIVED B.O.M.E.X.
MAY 30 95

REVISED 9/94

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

1651 E. Morten Avenue, Suite 210, Phoenix, AZ 85020

KINDLY COMPLETE AND SEND TO THE FEDERATION OF STATE MEDICAL BOARDS AT THE ADDRESS BELOW.

DATE: 4/28/95

Coordinator, Disciplinary Data Bank
Federation of State Medical Boards
400 Fuller Wiser Rd.
Euless, TX 76039

The ARIZONA BOARD OF MEDICAL EXAMINERS requests a disciplinary search concerning the following individual:

NAME: RAMOS (LAST) WILLIAM (FIRST) DOUGLAS (MIDDLE)

ADDRESS: [redacted]

City, State and Zip [redacted]

Date of Birth [redacted]

Social Security Number [redacted]

STATE U. OF NEW YORK, DOWNSTATE BROOKLYN, NY
Medical School of Graduation and Branch Location

6/3/76
Date of Graduation

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

MAY 16 1995

James R Winn, M.D.
JAMES R WINN M D
EXECUTIVE VICE-PRESIDENT

Please mail the response to the following:

Arizona Board of Medical Examiners
1651 East Morten Avenue, Suite 210
Phoenix, Arizona 85020

William O. Ramos M.D.
Signature

PCMEX

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE
SACRAMENTO, CA 95825-3236

(916) 263-2653

May 13, 1995

Arizona State Medical Board
1651 E. Morten Ave Ste 210
Phoenix, AZ 85020

TO WHOM IT MAY CONCERN:

This is to verify that Dr. William Douglas Ramos, born on [redacted], was issued California physician and surgeon's certificate #G 28860, on 2/7/75, based on National Board Credentials. This individual is no longer licensed in the State of California. The license was allowed to expire through non-payment of fees more than five years ago and under California statute, the licensee is not eligible to renew their certificate without completing a new application and passing the required examinations. There is no current record of accusation and/or disciplinary activity.

Patti Mahan
Licensing Program

To expedite the verification process, the above is the standard format used by the Medical Board of California.

SEAL

State of New Hampshire

BOARD OF REGISTRATION IN MEDICINE

2 INDUSTRIAL PARK DRIVE SUITE 8

CONCORD, NH 03301-8520

TDD Access Relay NH 1-800-735-2964

TEL. (603) 271-1203

This is to certify that the records of the New Hampshire Board of Registration in Medicine indicates the following information:

LICENSEE: WILLIAM D. RAMOS, M.D.

LICENSE NUMBER: 7527

ISSUE DATE: 3/4/87

EXPIRATION DATE: 6/30/91

DISCIPLINARY ACTION: NONE

DATE: 5/10/95

To expedite the certification of licensure process, the above is the standard format for all professionals regulated by this board.

Karen laCroix
Administrator

(SEAL)

KL/se

ARIZONA STATE BOARD OF MEDICAL EXAMINERS

MEDICAL AGENCY OF EMPLOYMENT

Dear Sir:

In applying for a license to practice medicine in the State of Arizona, the Medical Board requires this form to be completed by the medical agency wherein I am currently or have veen employed for the past five years. This is your authority to release any information in your files, favorable or otherwise, **DIRECT TO THE BOARD OF MEDICAL EXAMINERS, STATE OF ARIZONA, 1651 EAST MORTEN AVENUE, SUITE#210, PHOENIX, ARIZONA 85020.**

NAME: William Ramos M.D. William Ramos M.D.
(signature)

ADDRESS: [redacted], DATE: 10/16/98

CITY [redacted] STATE [redacted] ZIP [redacted]

The Physician named above stipulates his/her whereabouts as including employment with your medical agency. We would appreciate your comments as to current or prior employment, together with any information you may possess, favorable or otherwise, regarding the doctor's employment. If additional space is required, please use the back of this form.

NAME OF MEDICAL AGENCY: CHOICES WOMENS MEDICAL CENTER, INC
ADDRESS: 97-77 QUEENS BLVD FOREST HILLS N.Y. 11374 718-275-6020

Dates of employment with your agency: FROM: 10 TO 1990
(MONTH & YEAR)

Names, location and dates of each hospital/office/clinic wherein the doctor was/is assigned: CHOICES WOMENS MEDICAL CENTER, INC 97-77 QUEENS BLVD FOREST HILLS N.Y. 11374 718-275-6020

Were doctor's services performed in a satisfactory manner? Y/N, If no, please explain YES

Derogatory information, if any: NONE

Name and address of other source wherein additional information may be obtained, if applicable

Your name and title: Associate Medical Director M. SOMANI, M.D./CHOICES 97-77 Queens Blvd. Forest Hills, N.Y. 11374 (718) 275-6020
Signature: [signature]

Date: 10/18/98

[AGENCY SEAL OR STAMP]
PLEASE INDICATE IF NONE

BOME OCT 19

FEDERAL EXPRESS

RECIPIENT'S COPY

QUESTIONS? CALL 800-238-5355 TOLL FREE

3218073692

AIRBILL
PACKAGE
TRACKING NUMBER

3218073692

Date 10/18/95

From (Your Name) Please Print
WILLIAM RAMOS MD

Your Phone Number (Very Important) (718) 548-8157

Company
C HUGES MEDICAL

Department/Floor No

Street Address
3205 ARLINGTON AVE

City DALLAS State NY ZIP Required 10463

To (Recipient's Name) Please Print
MARIA VELASQUEZ

Recipient's Phone Number (Very Important) (602) 255-3751

Company
AZ DEPT MEDICAL EXAM.

Department/Floor No EXT 7104

Exact Street Address (We Cannot Deliver to PO Boxes or PO Zip Codes)
1651 EAST MORTEN AV Suite 210

City PHOENIX State AZ ZIP Required 85020-4160

YOUR INTERNAL BILLING REFERENCE INFORMATION (optional) (First 24 characters will appear on invoice)

IF HOLD AT FEDEX LOCATION, Print FEDEX Address Here
Street Address

City State ZIP Required

PAYMENT 1 [X] Bill Sender 2 [ ] Bill Recipient's FedEx Acct No 3 [ ] Bill 3rd Party FedEx Acct No 4 [ ] Bill Credit Card 5 [ ] Cash/Check

SERVICES (Check only one box)

Priority Overnight (Delivery by next bus ness morning†)
- 11 [ ] OTHER PACKAGING
- 16 [ ] FEDEX LETTER*
- 12 [ ] FEDEX PAK*
- 13 [ ] FEDEX BOX
- 14 [ ] FEDEX TUBE

Standard Overnight (Delivery by next business afternoon No Saturday del very†)
- 51 [ ] OTHER PACKAGING
- 56 [X] FEDEX LETTER*
- 52 [ ] FEDEX PAK*
- 53 [ ] FEDEX BOX
- 54 [ ] FEDEX TUBE

Economy Two-Day (Del ery by second business da y †)
- 30 [ ] ECONOMY*

* Economy Letter Rate not available Minimum charge One pound Economy rate

Government Overnight (Restricted to authorized users only)
- 46 [ ] GOV'T LETTER
- 41 [ ] GOV'T PACKAGE

Freight Service (for packages over 150 lbs.)
- 70 [ ] OVERNIGHT FREIGHT** (Confirmed reservation required)
- 80 [ ] TWO-DAY FREIGHT**

† Delivery commitment may be later in some areas

Declared Value Limit $500 Call for delivery schedule

DELIVERY AND SPECIAL HANDLING (Check services required)

Weekday Service
- 1 [ ] HOLD AT FEDEX LOCATION WEEKDAY (Fill in Section H)
- 2 [X] DELIVER WEEKDAY

Saturday Service
- 31 [ ] HOLD AT FEDEX LOCATION SATURDAY (Fill in Section H)
- 3 [ ] DELIVER SATURDAY (Extra charge) (Not available to all locations)
- 9 [ ] SATURDAY PICK-UP (Extra charge)

Special Handling
- 4 [ ] DANGEROUS GOODS (Extra charge)
- 6 [ ] DRY ICE Dangerous Goods Shipper's Declaration not required

Dry Ice 9 UN 1845 X ___ kg 904 III

- 12 [ ] HOLIDAY DELIVERY (If offered) (Extra charge)

PACKAGES	WEIGHT In Pounds Only	YOUR DECLARED VALUE (See right)
Total	Total	Total

DIM SHIPMENT (Chargeable Weight) [ ] ___ ___ ___ lbs

L x W x H

Received At

1 [ ] Regular Stop 3 [ ] Drop Box
2 [ ] On Call Stop 4 [ ] B S C 5 [ ] Station

7 Release Signature

Emp No Date

- [ ] Cash Received
- [ ] Return Shipment
- [ ] Third Party [ ] Chg To Del [ ] Chg To Hold

Street Address

City State Zip

Received By
X

Date/Time Received FedEx Employee Number

Federal Express Use
- Base Charges
- Declared Value Charge
- Other 1
- Other 2
- Total Charges

REVISION DATE 4/94
PART #145413 GBFE
FORMAT #160

160

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA
1651 East Morten Avenue, Suite 210, Phoenix, Arizona 85020, (602) 255-3751

HOSPITAL AFFILIATION

Dear Sir:

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by the Medical Staff Office in each hospital where I have held privileges, consultation or teaching appointments during the five years preceding my application. This is your authority to release any information in your files of record, favorable or otherwise, DIRECTLY to the ARIZONA BOARD OF MEDICAL EXAMINERS, 1651 E. Morten Avenue, Suite 210, Phoenix, Arizona 85020. Your early response will be appreciated.

NAME: William D. RAMOS, M.D. William D. Ramos M.D., M.D.
(SIGNATURE)

ADDRESS: 3205 ARLINGTON AVE.
BRONX, NY 10463

==========

(DO NOT DETACH)

1. What privileges were extended to the applicant? Ass't Attending
2. DATES: FROM: JAN. 13, 1994 TO: Present
3. Were any limitations imposed on such privileges? NO
   If YES, please explain.
4. Were staff privileges ever removed or restricted?
   If YES, please explain.
   Derogatory Information, if any

Names of other hospital affiliations, if known (list name, city and state):

1. N/A
2.
3.
4.

Comments, if any:

Director, Medical Staff: Robert G. Campbell, M.D.
Hospital Name: ST. Luke's Roosevelt Hospital Center
Address: 1111 Amsterdam Ave. City & State: NY, NY
Date: Signature: Robert G Campbell
Exec. V. P., Medical Director
(TYPED OR PRINTED)

STAMP OR SEAL OF HOSPITAL
IF NO SEAL, PLEASE INDICATE

RECEIVED B.O.M.E.X.
JUN 26 95

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

1651 East Morten Avenue, Suite 210, Phoenix, Arizona 85020, (602) 255-3751

TO: HOSPITAL DIRECTOR OF MEDICAL STAFF

Gillian Ramos, M.D. is applying for a license to practice medicine in the State of Arizona. In compliance with the licensing requirements of the Arizona Medical Practice Act, we are requesting that you complete the back of this form and return it DIRECTLY to the ARIZONA BOARD OF MEDICAL EXAMINERS, 1651 E. Morten Avenue, Suite 210, Phoenix, Arizona 85020. Your early response will be appreciated.

CHAPTER 13 - MEDICINE & SURGERY
Arizona Revised Statutes
ARTICLE I
BOARD OF MEDICAL EXAMINERS

§32-1403. Powers and duties of the board; compensation; immunity

A. The primary duty of the board is to protect the public from unlawful, incompetent, unqualified, impaired or unprofessional practitioners of allopathic medicine through licensure, regulation and rehabilitation of the profession in this state. The powers and duties of the board include.

1. Ordering and evaluating physical, psychological, psychiatric and competency testing of licensed physicians and candidates for licensure as may be determined necessary by the board.

2. Initiating investigations and determining on its own motion if a doctor of medicine has engaged in unprofessional conduct or provided incompetent medical care or is mentally or physically unable to engage in the practice of medicine.

ARTICLE 2
LICENSING

§32-1422. Basic requirements for granting a license to practice medicine

A. An applicant for a license to practice medicine in this state pursuant to this article shall meet each of the following basic requirements:

1. Graduate from an approved school of medicine or receive a medical education which the board deems to be of equivalent quality.

2. Successfully complete an approved twelve month hospital internship, residency or clinical fellowship program.

3. Have the physical and mental capability to safely engage in the practice of medicine.

4. Have a professional record which indicates that the applicant has not committed any act or engage in any conduct which would constitute grounds for disciplinary action against a licensee under this chapter.

5. Have a professional record which indicates that the applicant has not had a license to practice medicine refused, revoked, suspended or restricted in any way by any state, territory, district or country for reasons which relate to his ability to competently and safely practice medicine.

B. The board may require the submission of such credentials or other evidence, written and oral, and make such investigation as it deems necessary to adequately inform itself with respect to an applicant's ability to meet the requirements prescribed by this section, including a requirement that the applicant for licensure undergo a physical examination, a mental evaluation and an oral competence examination and interview, or any combination thereof, as the board deems proper.

Mark R. Speicher

MARK R. SPEICHER, EXECUTIVE DIRECTOR
ARIZONA BOARD OF MEDICAL EXAMINERS

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

1651 East Morten Avenue, Suite 210, Phoenix, Arizona 85020, (602) 255-3751

HOSPITAL AFFILIATION

Dear Sir:

In applying for a license to practice medicine in Arizona, the Medical Board requires this form to be completed by the Medical Staff Office in each hospital where I have held privileges, consultation or teaching appointments during the five years preceding my application. This is your authority to release any information in your files of record, favorable or otherwise, DIRECTLY to the ARIZONA BOARD OF MEDICAL EXAMINERS, 1651 E. Morten Avenue, Suite 210, Phoenix, Arizona 85020. Your early response will be appreciated.

NAME: William D. Ramos, M.D. William D. Ramos M.D., M.D.
(SIGNATURE)

ADDRESS: 3205 ARLINGTON AVE
BRONX, NY 10463

==========

(DO NOT DETACH)

1. What privileges were extended to the applicant? OB/GYN
   ASSOCIATE Attending
2. DATES: FROM: 8/7/92 TO: Present
3. Were any limitations imposed on such privileges? NO
   If YES, please explain.
4. Were staff privileges ever removed or restricted? NO
   If YES, please explain.
   Derogatory Information, if any

Names of other hospital affiliations, if known (list name, city and state):

1. ROOSEVELT/ST. LUKES
2. CHOICES WOMEN'S MEDICAL
3.
4.

Comments, if any:

E. HAKIM ELAHI, M.D.
MEDICAL DIRECTOR
LA GUARDIA HOSPITAL
102-01 66th ROAD
FOREST HILLS, NY 11375

Director, Medical Staff:
Hospital Name:
Address: City & State:
Date: 6/2/95 Signature:
(TYPED OR PRINTED)

STAMP OR SEAL OF HOSPITAL
IF NO SEAL, PLEASE INDICATE

RECEIVED B.O.M.E.X.
JUN -8 95

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

1651 East Morten Avenue, Suite 210, Phoenix, Arizona 85020, (602) 255-3751

TO: HOSPITAL DIRECTOR OF MEDICAL STAFF

William D. Rose, M.D. is applying for a license to practice medicine in the State of Arizona. In compliance with the licensing requirements of the Arizona Medical Practice Act, we are requesting that you complete the back of this form and return it DIRECTLY to the ARIZONA BOARD OF MEDICAL EXAMINERS, 1651 E. Morten Avenue, Suite 210, Phoenix, Arizona 85020. Your early response will be appreciated.

CHAPTER 13 - MEDICINE & SURGERY
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ARTICLE 2
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5 Have a professional record which indicates that the applicant has not had a license to practice medicine refused, revoked, suspended or restricted in any way by any state, territory, district or country for reasons which relate to his ability to competently and safely practice medicine.

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Mark R. Speicher

MARK R. SPEICHER, EXECUTIVE DIRECTOR
ARIZONA BOARD OF MEDICAL EXAMINERS

RAMOS, William
(FOR OFFICE USE ONLY)

PRELIMINARY QUESTIONNAIRE

(ENDORSEMENT)

THIS IS NOT AN APPLICATION FOR LICENSE

To respond accurately to your recent inquiry, we will need the answers to *all* of the following questions to determine your eligibility for Arizona licensure *Unless this Preliminary Form is completed in full and all questions answered, it cannot be evaluated, nor an application sent to you* Return the completed form as soon as possible to ARIZONA BOARD OF MEDICAL EXAMINERS, 1651 East Morten Avenue, Suite 210, Phoenix Arizona 85020 PLEASE *PRINT* ALL INFORMATION

Full Legal Name: WILLIAM (FIRST) DOUGLAS (MIDDLE) RAMOS (LAST)

Current Office Address: 3205 ARLINGTON AVE

Area Code: (718)

City: BRONX State: NY Zip Code: 10463 Phone: 275-6020

Current Residence Address. [redacted]

Area Code: [redacted]

City: [redacted] State [redacted] Zip Code: [redacted] Phone. [redacted]

035-08

MEDICAL SCHOOL: Name STATE U. OF NEW YORK, DOWNSTATE

City and State: BROOKLYN, NY 11203 Date of Degree

If transferred from other medical school, please indicate name: NONE

Name of any medical school attended but did not graduate or transfer from: NONE

5TH PATHWAY PROGRAM: U.S. Medical School: NONE

HOSPITAL: City: State

Term: Started (MONTH AND YEAR) Completed (MONTH AND YEAR)

INTERNSHIP: (List U S. & Canadian only) **HOSPITAL:** KINGS COUNTY HOSP.

City: BROOKLYN State: NY

Term. Started: 7/70 (MONTH AND YEAR) Completed: 6/71 (MONTH AND YEAR)

RESIDENCY/FELLOWSHIP: (List U S & Canadian only) **HOSPITAL:** KINGS COUNTY HOSP

City: BROOKLYN State: NY

Term Started: 7/71 (MONTH AND YEAR) Completed 12/74 (MONTH AND YEAR)

Specialty Field: OB/GYN

RESIDENCY/FELLOWSHIP: (List U S & Canadian only) **HOSPITAL:** DART MOUTH - HITCHCOCK MED. CTR.

City LEBANON State: NH

Term Started: 7/86 (MONTH AND YEAR) Completed: 6/90 (MONTH AND YEAR)

Specialty Field: PATHOLOGY - ANATOMIC & CLINICAL

FOR OFFICE USE ONLY

INFORMATION FORM FORWARDED 19

RECEIPT - PINK APPLICATION FORWARDED 4-17- 19 95

APPLICATION & FORMS I II III III-A IV AMA, FS NB2

5-Lic, 3-Hosp, 1-MAE

CLINICAL INSTRUCTOR - ASSISTANT PROFESSOR OR HIGHER (List U.S. & Canadian only)

TEACHING HOSPITAL: _____

City _____ State: _____

Medical School Affiliate: ~~UNIV OF NEVADA-RENO~~ SEE ATTCH

Term Started _____ (MONTH AND YEAR) Completed ~~6/88~~ (MONTH AND YEAR)

Specialty Field: OB/GYN, PATHOLOGY, FORENSIC PATHOLOGY

(NOTE Attach separate list for additional Residency/ Fellowship/ Clinical Instructor)

FOREIGN MEDICAL SCHOOL GRADUATES: ECFMG Cert. No _____ Date Issued _____

CLINICAL WRITTEN EXAMINATION: Refer to last page for required FLEX/ SPEX scores.

Please indicate which examinations you have succesfully passed

NATIONAL BOARD	USMLE	FLEX (taken after 1/1/85)
Part I 1968 (date)	Step I _____ (date)	Comp I _____ (date)
Part II 1970 (date)	Step II _____ (date)	Comp. II _____ (date)
Part III 1971 (date)	Step III _____ (date)	

FLEX examination taken prior to January 1, 1985 _____ (date)

Were grades achieved all in one sitting? _____ (yes) _____ (no)

State Board exam? ____ Name of State _____ License No. _____ Date iss _____

LMCC (Canadian) _____ Cert. No _____ Date iss._____

SPECIAL PURPOSE EXAMINATION:

(SPEX) _____ (STATE) Date SPEX examination taken: _____ (MONTH & YEAR)

Did you receive a minimum grade of seventy-five (75) ? _____

Are you a Diplomate of any of the *American* Medical Specialty Boards? Yes X No _____ .

If "Yes", which Board(s)? OB/GYN, PATHOLOGY (AP, CP & FP)

Have you completed the educational requirements for any of the *American* Medical Specialty Boards?

Yes _____ No _____ . If "Yes", which Board(s)? _____

LICENSES: List *all* States or Provinces in which you **have ever** held licensure.

(1) NEW YORK (2) CA (3) NV (4) NH (5) VT

(6) _____ (7) _____ (8) _____ (9) _____ (10) _____

LIST all hospital affiliations and locations for the past five (5) years (Other than Postgraduate Training Hospitals) Please list all hospital affiliations (including moonlighting) and medical agencies of employment, e g., physician placement group; emergency medical group, radiology group, etc.. La Guardia Hosp., Roosevelt/St. Lukes Hosp., Elmhurst Hosp., Choices Women's Medical Center.

(NOTE Attach separate list for additional hospital affiliations/medical agencies)

PRACTICE: City & State Where You Now Practice. NEW YORK, NY

Date Above Practice was Established: 1990

U.S. CITIZENSHIP:

(X) Birth
( ) Naturalization
( ) Declaration of Intention
( ) Hold Permanent Immigrant Status
( ) Awaiting Quota Assignment

BIRTHPLACE: [redacted] **DATE OF BIRTH:** [redacted]

MILITARY (United States Only).

( ) Army (X) Air Force ( ) USPHS
( ) Navy ( ) Marine Corps ( ) Coast Guard

Dates of Active Duty. 1/10/67 - 7/78 Type of Discharge: HONORABLE

Has any formal disciplinary or rehabilitation action including reprimand, censure, probation, restriction, limitation, suspension or revocation been taken against your license in any State/ Province? Yes _____ No X

Have you ever entered into a written consent agreement or stipulation with a State/ Province licensing or disciplinary agency? Yes _____ No X

If "Yes", indicate State/ Province _____

Reason for action and action taken. _____

(NOTE Attach separate sheet, if necessary)

Have you ever been convicted of Medicare/ Medicaid fraud? Yes _____ No X

If "Yes", when? _____

_____ Where? _____

Have your prescription/dispensing/or administration abilities ever been denied, restricted or modified by a Federal/ State/ Province government agency? Yes _____ No X

If "Yes", when? _____

Where? & By Which Agency? _____

Have you ever been involved in any malpractice matter which resulted in a settlement or judgement against you in excess of $20,000? Yes X No _____

Have you ever had hospital privileges revoked; denied, suspended or restricted in any way? Yes X No _____

If "Yes", name and address of hospital(s) _____

(NOTE Attach separate sheet, if necessary)

I DECLARE UNDER PENALTY OF PERJURY that my answers and all statements made by me herein are true and correct Should I furnish any false information on this Preliminary Questionnaire, I hereby agree that such shall constitute cause for the denial of my eligibility to apply for licensure as an allopathic physician in the State of Arizona

SIGNATURE William Nama M.D., M D DATE 4/3/95

REQUIREMENTS FOR ARIZONA LICENSURE

FOR GRADUATES OF APPROVED MEDICAL SCHOOLS (United States or Canada)

A Must have successfully completed 12 months hospital internship, residency or fellowship program which was approved by the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, the Royal College of Physicians and Surgeons of Canada or any similar body in the United States or Canada whose function is that of approving training programs.

B Must have successfully passed a complete written examination conducted by any state, territory or district of the United States, or be certified by the National Board of Medical Examiners as having passed either, all three parts of the National Board examination or all three Steps of the United States Medical Licensing examination, or be certified by the Licensing Medical Council of Canada, or passed the Federation Licensing Examination

Note: If applicant's written examination was the FLEX exam taken prior to January 1, 1985, must have been taken in one sitting and must have achieved a FLEX weighted average of at least 75

If FLEX was taken after January 1, 1985, both Component I and Component II must have been passed within a 5 year period and must have received at least a 75 in each Component

If applicant's written examination was the USMLE exam, all three Steps must have been taken within a 7 year period and must have received at least a 75 in each Step.

The following combinations of examinations (hybrids) are acceptable if taken from June 1, 1992 to July 31, 1995

1) Parts One and Two of the NBME *AND* either Step Three of the USMLE or Component II of FLEX.

2.) FLEX Component I *AND* Step Three of the USMLE.

3.) *EACH* of the following:

i.) NBME Part One or Step One of the USMLE

ii.) NBME Part Two or Step Two of the USMLE

iii.) NBME Part Three or Step Three of the USMLE or Component II of FLEX

C. An applicant seeking licensure by endorsement based on successful passage of a written examination which precedes by more than 10 years his application for licensure in this state, shall take and successfully complete a Special Purpose Examination (SPEX). An applicant who fails the SPEX exam 3 times, shall prove to the Board that he/she successfully completed an additional twelve months approved postgraduate training before retaking SPEX.

D. Must file an application for licensure by either Endorsement or Endorsement & SPEX.

E. Must pay all fees

F. Must contact the Federation of State Medical Boards at 6000 Western Place, Suite 707, Fort Worth, Texas 76107, to request that all FLEX and USMLE scores be sent to this office The Federation charges $40.00 for this service. (Scores must be received in this office before any application will be forwarded to the applicant.)

FOR GRADUATES OF UNAPPROVED ALLOPATHIC MEDICAL SCHOOLS

In addition to the above requirements, the following must be met:

1) Hold a standard certificate issued by the Educational Council for Foreign Medical Graduates, complete a Fifth Pathway program, or complete thirty-six months as a full-time Assistant Professor or higher position in an approved school of medicine

2) Successfully complete an approved twenty-four month hospital internship, residency or clinical fellowship program in addition to A. above, for a total of thirty-six months, unless the applicant successfully completed a Fifth Pathway program, or has served as a full-time Assistant Professor or higher position at an approved school of medicine

Note: The above examination requirements are statutorily set and cannot be waived by the Board

INTERNSHIP:

Kings County Hospital/SUNY Downstate
451 Clarkson Avenue
Brooklyn, NY 11203
Rotating/Obs-Gyn, 7/70-6/71

RESIDENCIES:

Kings County Hospital/SUNY Downstate
451 Clarkson Avenue
Brooklyn, NY 11203
Obs-Gyn, 7/71-12/74

Dartmouth-Hitchcock Medical Center
Hanover, NH 03756
Anatomic and Clinical Pathology 7/86-6/90

FELLOWSHIP:

Office of the Chief Medical Examiner
520 First Avenue
New York, NY 10016
Forensic Pathology, 7/90-6/91

ACADEMIC APPTS:

State University of New York
Downstate Medical Center
Clinical Assistant Prof. (Obs-Gyn), 1975

University of Nevada, School of Medicine
Clinical Assistant Prof. (Obs-Gyn), 1981-86

Dartmouth Medical School
Clinical Instructor in Pathology, 1989-90

New York University, School of Medicine
Department of Forensic Pathology
Instructor, 1990-91
Assistant Professor, 1991-92

BOARDS:

National Board of Medical Examiners
Diplomate, 1971

American Board of Obstetrics & Gynecology
Certified 1976

American Board of Pathology
Anatomic/Clinical Pathology, Certified 1990
Forensic Pathology, Certified 1991

STATE LICENSURE:

New York
Number: 108816
Issued: 1971
Status: Current

California
Number: G 028860
Issued: 1975
Status: Pending Reissue
Oral Examination Passed Dec. 1994.

Nevada
Number: 3597
Issued: 1978
Status: Inactive

New Hampshire
Number: 7527
Issued: 1987
Status: Inactive

Vermont
Number: 42-0007546
Issued: 1987
Status: Inactive

HOSPITAL PRIVILEGES:

My privileges at:

Washoe Medical Center
77 Pringle Way
Reno, NV 89502

and

St. Mary's Hospital
235 West Sixth Street
Reno, NV 89503

were revoked in 1985 and 1986 respectively solely because I refused to carry malpractice insurance. This was a new requirement instituted at that time, as I had practiced without insurance at both hospitals since 1984.

A-Z WOMEN'S CENTER, INC.
1002 EAST McDOWELL ROAD
SUITE B
PHOENIX, ARIZONA 85006
(602) 957-8535

RAMOS, William

March 20, 1995

Arizona State Licensure Board
1651 E. Morten Drive
Suite # 210
Phoenix, Arizona 85020

Dear Sir/Madame:

Please send an application for state licensure to the following address:

Dr. William Ramos
3205 Arlington Avenue
Bronx, New York 10463

Your prompt attention to this matter is greatly appreciated.

Thank You,

Ms. Joy L. Noll

Ms. Joy Noll
Supervisor

Sent: PQ
AMG/FG
3-27-95

National Board of Medical Examiners

of the

United States of America

William Douglas Ramos, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a

Diplomate of the National Board of Medical Examiners

Attest

J. Myers
Chairman of the Board

John A. Hubbard
President of the Board

Philadelphia, Pa.
July 1, 1971

Certificate No. 109668

BOMEX

MAY - 9 1995

Dale M. Carrison, D.O.
Chief of Staff

John J. Fildes, M.D.
Vice-Chief of Staff

Michael J. Casey, M.D.
Secretary

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

Medical Staff Department, 1800 W. Charleston Boulevard, Las Vegas, NV 89102 (702) 383-2603 FAX (702) 383-2999

October 3, 2014

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

RE: William D. Ramos, M.D.

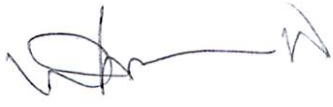
Dear Chief of Staff:

This letter is in response to your recent inquiry for verification of Medical Staff membership and privileges at University Medical Center of Southern Nevada for **William D. Ramos, M.D.**.

The above-named physician was granted Medical Staff membership and privileges at our facility on **December 31, 1996** and currently has **Refer and Follow** Staff privileges, in good standing, in the Department of **Obstetrics and Gynecology.** Dr. Ramos was changed to Refer and Follow status due to the level of patient activity he had in the last year.

Since this physician's last reappointment, according to our records, this physician's membership and/or clinical privileges at this hospital have not been suspended, denied, revoked, restricted, granted with limitations (aside from ordinary and initial requirements for supervision/monitorship/proctorship), not renewed, subject to probationary conditions, or not approved by the Board of Trustees (excluding temporary suspensions for incomplete medical records). Dr. Ramos has complied with Bylaws and Rules and Regulations provisions and has demonstrated current clinical competence and ethical conduct in exercising his privileges at this hospital. To the best of our knowledge, we are unaware of any physical, mental health, drug, alcohol, or other problems which the applicant may have had previously or presently has which could potentially impair his present ability to practice the privileges granted.

Verified by Yvette S. Burton.



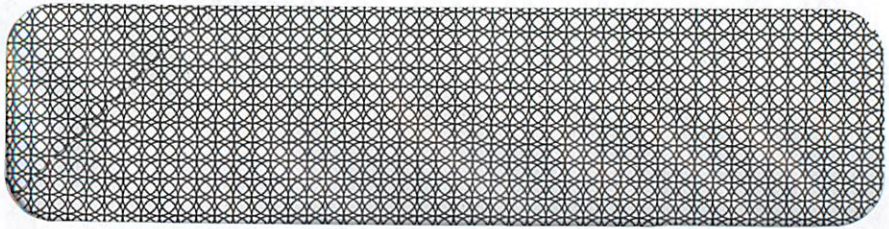
Dale M. Carrison, D.O.
Chief of Staff

/ysb

UMC
UNIVERSITY MEDICAL CENTER
1800 W. Charleston Blvd.
Las Vegas, NV 89102-2386

8710/MS

RETURN SERVICE REQUESTED



86 HRDFNMP 65258

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OCT 08 2014
MAILED FROM ZIP CODE 89102

Arizona Medical Board

9545 E. Doubletree Ranch Road, Scottsdale AZ 85258 • website: www.azmd.gov
Phone (480) 551-2700 • Toll Free (877) 255-2212 • Fax (480) 551-2707

September 19, 2014

Dr. Ramos
[redacted]

This will acknowledge receipt of your renewal application for licensure to practice medicine in the State of Arizona. I have reviewed your renewal application. To complete the processing of your renewal application, the following deficient documentation is still required:

1.) **You answered "Yes" to a Professional Conduct or Confidential Question on your application. Please submit the following additional information.**
   a. A detailed written narrative concerning your "Yes" answer.
   b. Documentation to support your "Yes" answer. Specifically, a letter from University Medical Center Southern Nevada regarding your membership to "refer & follow"
2.) **Please submit a full set of fingerprints on the fingerprint card provided by the Board for purposes of obtaining a state and federal criminal records check. If you have not received a fingerprint packet provided by the Board within two weeks of your renewal payment, please do not hesitate to contact the Board.**

PLEASE NOTE: IF THE ABOVE DEFICIENT ITEMS ARE NOT RECEIVED WITHIN 60 DAYS OF THIS DEFICIENCY NOTICE, YOUR ARIZONA MEDICAL LICENSE WILL EXPIRE ON ITS SCHEDULED EXPIRATION DATE. ANY DEFICIENT ITEMS THAT ARE RECEIVED AFTER THE 60 DAY PERIOD WILL NOT BE ACCEPTED. IF YOUR LICENSE EXPIRES YOU MAY REAPPPLY AS AN INITIAL APPLICANT.

Should you wish to appeal any item in this deficiency letter you must submit your request for a hearing to the Board pursuant to AAC R4-16-206(B)(2) within 30 days from the date of this notice.

A.R.S. § 32-1430:
B. A person renewing an active license to practice medicine in this state shall provide to the board as part of the renewal process a report of disciplinary actions, restrictions or any other action placed on or against that person's license or practice by another state licensing or disciplinary board or an agency of the federal government. This action may include denying a license or failing the special purpose licensing examination. The report shall include the name and address of the sanctioning agency or health care institution, the nature of the action taken and a general statement of the charges leading to the action taken.
C. The licensee shall submit proof with the renewal form of having completed a training unit as prescribed by the board relating to the requirements of this chapter and board rules.
D. A person whose license has expired may reapply for a license to practice medicine as provided in this chapter.
E. Beginning September 2, 2014, if a person did not submit fingerprints for a criminal records check when the person was initially licensed pursuant to section 32-1422, the person renewing an active license to practice medicine in this state for the first time on or after September 2, 2014 shall submit a full set of fingerprints to the board for the purpose of obtaining a state and federal criminal records check pursuant to section 41-

1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation.

R4-16-207. Time-frames for License Renewal; Expiration
B. For license renewal, the administrative completeness review time-frame described in A.R.S. § 41-1072(1) is 45 days and begins on the date the Board receives the renewal application.
1. If the required application is not administratively complete, the Board shall send a written deficiency notice to the applicant.
a. In a deficiency notice, the Board shall state each deficiency and the information required to complete the application or supporting documentation.
b. Within 60 days after the Board sends a deficiency notice, the applicant shall submit to the Board the requested documentation or information specified in the notice. The time-frame for the Board to finish the administrative completeness review is suspended from the date of the notice until the date the Board receives the requested documentation or information from the applicant.
D. If a person holding an active license does not apply for license renewal according to the biennial renewal requirement or fails to meet time-frame requirements under this Section, the person's license expires according to provisions prescribed under A.R.S § 32-1430(A) unless the person is under investigation according to provisions prescribed under A.R.S. § 32-3202.

Sincerely,

Sara Bachmann
Arizona Medical Board
Sara.Bachmann@azmd.gov
Fax: 480-551-2704

Arizona Medical Board

9545 E. Doubletree Ranch Road, Scottsdale AZ 85258 • website: www.azmd.gov
Phone (480) 551-2700 • Toll Free (877) 255-2212 • Fax (480) 551-2707

August 8, 2014

Dr. Ramos,
[redacted]

Thank you for beginning your renewal for your Arizona Medical Board license.

You answered "Yes" to Professional Conduct #5 which asks "Since 2009, have you had hospital privileges revoked, denied, suspended, or restricted?" Due to your answer you must submit additional information no later than **October 7, 2014**.

In response to your renewal answer, you must submit a detailed report concerning your answer(s), including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such matters. In addition, you must submit photocopies of any corresponding documents, such as a complaint or board action in accordance with:

A.R.S. 32-1430(B). A person renewing an active license to practice medicine in this state shall attach to the completed renewal form a report of disciplinary actions, restrictions or any other action placed on or against that person's license or practice by another state licensing or disciplinary board or an agency of the federal government. This action may include denying a license or failing the special purpose licensing examination. **The report shall include the name and address of the sanctioning agency or health care institution, the nature of the action taken and a general statement of the charges leading to the action taken.**

Your license will not be renewed until such information is received. If information is not received by **October 7, 2014** an investigation may be opened.

NOTE: If the required documents are not submitted to the Board by your expiration date, your license will expire and you may not practice medicine in Arizona. You would, however, have the option to reapply for an Arizona medical license.

Please contact me with any questions.

Sincerely,

Sara Bachmann
Arizona Medical Board

AMB - Physician Renewal - Confirmation (Step 8 of 11)

8/6/2014

William Douglas Ramos

Please review the information below and click at the bottom to accept. If you need to correct the information, click the links below the records.

General Questions

Note: ***In the event the response to any of the questions numbered 1 through 10 is â€œYESâ€***, you must file by fax or mail a detailed report concerning the below matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such matters. IN ADDITION, you must submit photocopies of any corresponding documents, such as complaints or board actions.

1) Since 2009, have you had an application for medical licensure denied or rejected by another state or province licensing board? If so, provide an explanation.

No

2) Since 2009, has any disciplinary or rehabilitative action been taken against you by another licensing board, including other health professions? If so, provide an explanation.

No

3) Since 2009, have any disciplinary actions, restrictions or limitations taken against you while participating in any type of program or by any health care provider? If so, provide an explanation.

No

4) Since 2009, have you had a medical license disciplined resulting in a revocation, suspension, limitation, restriction, probation, voluntary surrender, cancellation, during an investigation or entered into a consent agreement or stipulation? If so, provide an explanation.

No

5) Since 2009, have you had hospital privileges revoked, denied, suspended, or restricted? If so, provide an explanation.

Yes

University Medical Center Southern Nevada membership reduced to "Refer & Follow" because of insufficient admissions to hospital.

6) Since 2009, Have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by any agency of the federal or state government? If so, provide an explanation.

No

7) Since 2009, have you had your authority to prescribe, dispense, or administer medications limited, restricted, modified, denied, surrendered, or revoked by a federal or state agency? If so, provide an explanation.

No

8) Since 2009, have you engaged or do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication? If so, provide an explanation.

[redacted]

9) Since 2009, have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state? Is so, provide an explanation. See list of Moral Turpitude items at .

No

10) Since 2009, have you failed the special purpose licensing examination (SPEX)?

No

Physical/Mental Health and Substance Abuse Questions

In the event you answer YES to any of the below questions, you must file with the application a detailed written narrative statement concerning the above matter(s), including the name of healthcare providers and treatment centers where you were treated, along with the discharge summary of your treatment and progress. If you are currently participating or have participated in the past 5 years pursuant to a confidential agreement or order in a program for the treatment and rehabilitation of physician assistantâ€™s impaired by alcohol, drug abuse or for other issues, please submit a copy of the agreement/order along with a compliance reports from the state monitoring programs

FAILURE TO PROPERLY ANSWER THESE QUESTIONS OR DISCLOSE ALCOHOL, SUBSTANCE ABUSE OR OTHER ISSUES CAN RESULT IN BOARD DISCIPLINARY ACTION.

1) Since 2009, have you had or do you have a medical condition that impairs or limits your ability to safely practice medicine including diagnosis or treatment for any psychotic disorder or substance abuse disorder? If so, provide an explanation.

[redacted]

2) Since 2009, have you consumed intoxicating beverages resulting in your ability being impaired or limited to exercise the judgment and skills of a medical professional? If so, provide an explanation

[redacted]

Citizenship Status

I am a U.S. Citizen or U.S. National

Specialties

	Specialty	Certified?	Practicing?	Date Certified	Expiration Date
Primary Specialty	Gynecology	Yes	Yes		
Specialty 2	Anatomic/Clinical Pathology	Yes	Yes		
Specialty 3	Forensic Pathology (Pathology)	Yes	No		
Specialty 4					

Practice Address

(Directory Address)
1670 E Flamingo Rd Ste C
Las Vegas NV, 89119-5120
Phone: (702) 892-0660
Fax: (702) 650-0549

You are required to enter a valid address, if you have one.

Home Address

[redacted]

You are required to enter a valid address, if you have one.

Mailing Address

1670 E Flamingo Rd Ste C

Las Vegas NV, 89119-5120
[redacted]

You are required to enter a valid address, if you have one.

CME Audit Information

Dates	Type of CME Activity	# of Credit Hours
04/22/2012	National Abortion Federation, Post Graduate Seminar	6.0
04/23/2012	National Abortion Federation 36th Annual Meeting	13.75
04/28/2013	National Abortion Federation, Post Graduate Seminar	6.0
04/29/2013	National Abortion Federation 37th Annual Meeting	13.75
06/15/2012	Reproductive Health Access, Contraceptive Pearl	1.0
09/11/2012	Reproductive Access Project, Contraceptive Pearls	1.0

Please review all information you have provided. Change any information given or click on the I Agree button to verify that all information posted above is correct and to proceed to payment options.

By agreeing with this data, you are signing this registration form and certifying under pentalty of perjury that all information on this form is currently accurate and:

· I am a U.S. Citizen or a qualified/registered alien

· I have completed a minimum of 40 credit hours of continuing medical education during the two calendar years preceding renewal year as required by A.R.S. Â§32-1434 and A.A.C. Â§ R4-16-101

· I have a written protocol in place for the secure storage, transfer and access of the medical records of my patients should my practice close as required by A.R.S. Â§32-3211.

I Agree ○ **Yes** ◉ **No**

MD Training Unit

Complete

You may wish to print this Page for your records.

After pressing the ***Next*** button, please be patient, as it may take a few moments to process your data and send you to the payment page.

Back Next

Arizona Medical Board: License Renewal Questions

William Ramos 2012 License # 23599 Professional Conduct

1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	**No**	
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	**No**	
3. Since your last renewal have you voluntarily surrendered any healthcare license?	**No**	
4. Since your last renewal have you had any healthcare license revoked?	**No**	
5. Since your last renewal have you been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license (other than by the Arizona Medical Board), have you been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	**No**	
6. Since your last renewal have your privileges been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	**No**	
7. Since your last renewal, has disciplinary action been taken against you by any licensing agency (other than the Arizona Medical Board) with regard to any professional license? -Disciplinary Action- includes, but is not limited to, restriction, termination, voluntary or involuntary resignation or withdrawn.	**No**	
8. Since your last renewal have you had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied or have you surrendered or given up in lieu of action?	**No**	
9. Since your last renewal have you been charged with or convicted, pardoned or had a record expunged or vacated of a felony, misdemeanor involving moral turpitude? (see explanation below) A -yes- answer is required even if you entered a diversion program.	**No**	
10. Since your last renewal have you been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	**No**	
11. Since your last renewal have you been court martialed or discharged other than honorably from the armed service?	**No**	
12. Since your last renewal have you been terminated from a healthcare position with a city, county, or state government or the Federal government?	**No**	
13. Since your last renewal have you been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	**No**	

Arizona Medical Board: License Renewal Questions

William	Ramos	2012	License # 23599	Mental Health

1. Since your last renewal, have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?	[redacted]
2. Are you now being treated or since your last renewal have you been treated or for a drug or alcohol addiction or participated in a rehabilitation program? *If in a confidential program in another state see explanation below	
3. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1)behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice? See below for definition of ability to practice medicine.	

Arizona Medical Board: License Renewal Questions

William Ramos 2010 License # 23599 Professional Conduct

1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	**No**	
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	**No**	
3. Since your last renewal have you voluntarily surrendered any healthcare license?	**No**	
4. Since your last renewal have you had any healthcare license revoked?	**No**	
5. Since your last renewal have you been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license (other than by the Arizona Medical Board), have you been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	**No**	
6. Since your last renewal have your privileges been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	**No**	
7. Since your last renewal, has disciplinary action been taken against you by any licensing agency (other than the Arizona Medical Board) with regard to any professional license? -Disciplinary Action- includes, but is not limited to, restriction, termination, voluntary or involuntary resignation or withdrawn.	**No**	
8. Since your last renewal have you had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied or have you surrendered or given up in lieu of action?	**No**	
9. Since your last renewal have you been charged with or convicted, pardoned or had a record expunged or vacated of a felony, misdemeanor involving moral turpitude? (see explanation below) A -yes- answer is required even if you entered a diversion program.	**No**	
10. Since your last renewal have you been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	**No**	
11. Since your last renewal have you been court martialed or discharged other than honorably from the armed service?	**No**	
12. Since your last renewal have you been terminated from a healthcare position with a city, county, or state government or the Federal government?	**No**	
13. Since your last renewal have you been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	**No**	

Arizona Medical Board: License Renewal Questions

William	Ramos	2010	License # 23599	Mental Health

1. Since your last renewal, have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?

2. Are you now being treated or since your last renewal have you been treated or for a drug or alcohol addiction or participated in a rehabilitation program? *If in a confidential program in another state see explanation below

3. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1)behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice? See below for definition of ability to practice medicine.

ARIZONA MEDICAL BOARD
BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 23599 **Renewal Fee: $500 $850** (if postmarked 30 days after due date)

Name: William D. Ramos , **MD**

OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS
PUBLIC ADDRESS & PHONE NUMBER

1670 E. Flamingo Rd, Ste C
Las Vegas, NV 89119
702-892-0660

Phone #: 702-892-0660 **Fax #:** 702-650-0549

E-Mail:

MAILING ADDRESS

S Ame

AUG 6 2008

HOME ADDRESS

[redacted]

Phone #:

Mobile #:

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

Only certifications from ABMS will be shown in your profile on the website. Please indicate expiration date or lifetime certificate.

Field of Practice Code (see attached form for code)	ABMS Certified? (Y/N)	Practicing? (Y/N)	Expiration Date (or indicate lifetime certificated)
GYN	Y	Y	LIFETIME
PTH	Y	Y	LIFETIME
FOP	Y	N	LIFETIME

REQUEST FOR CHANGE IN LICENSE STATUS:

- ☐ **INACTIVE STATUS** (I have read and meet the requirements for Inactive status as listed in the instructions)
- ☐ **CANCELLATION** (I have read and meet the requirements to cancel my license as listed in the instructions)

I hereby certify, under penalty of perjury by my signature below that all information on this form is currently accurate and

- I have completed a minimum of 40 credit hours of continuing medical education during the previous two calendar years of my renewal as required by A.R.S. §32-1434 and A.A.C. § R4-16-101
- I have a written protocol in place for the secure storage, transfer and access of the medical records of my patients should my practice close as required by A.R.S. §32-3211

☒ **I am a U.S. Citizen or U.S. National** (If this box is checked please submit with your application a copy of one of the listed approved supporting documents listed in the "Arizona Statement of Citizenship and Alien Status for State Public Benefits" i.e. Birth Certificate, U.S. Passport, etc.)

☐ **I am NOT a U. S. Citizen or U.S. National** (If this box is checked you must download, complete and submit with your application "Arizona Statement of Citizenship and Alien Status for State Public Benefits" form along with a copy of one of the listed approved supporting documents i. e. Alien Registration Card, Visa, etc.)

William D. Ramos M.D. 7/31/08 AUG 06

Signature of Licensee (Signature stamp will not be accepted) Date

1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	YES ☐	NO ☒
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	YES ☐	NO ☒
3. Since your last renewal have you voluntarily surrendered any healthcare license?	YES ☐	NO ☒
4. Since your last renewal have you had any healthcare license revoked?	YES ☐	NO ☒
5. Since your last renewal, have you been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license (other than by the Arizona Medical Board), have you been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☒	NO ☐
6. Since your last renewal have your privileges been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐	NO ☒
7. Since your last renewal, has disciplinary action been taken against you by any licensing agency (other than the Arizona Medical Board) with regard to any professional license? "Disciplinary Action" includes, but is not limited to, restriction, termination, voluntary or involuntary resignation or withdrawn.	YES ☐	NO ☒
8. Since your last renewal have you had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied or have you surrendered or given up in lieu of action?	YES ☐	NO ☒
9. Since your last renewal have you been charged with or convicted, pardoned or had a record expunged or vacated of a felony, misdemeanor involving moral turpitude? (see explanation below) A "yes" answer is required even if you entered a diversion program.	YES ☐	NO ☒
10. Since your last renewal have you been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	YES ☐	NO ☒
11. Since your last renewal have you been court martialed or discharged other than honorably from the armed service?	YES ☐	NO ☒
12. Since your last renewal have you been terminated from a healthcare position with a city, county, or state government or the Federal government?	YES ☐	NO ☒
13. Since your last renewal have you been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	YES ☐	NO ☒

Note: ***In the event the response to any of the questions numbered 1 through 13 is "YES",*** you must file with the renewal a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such matters. IN ADDITION, you must submit photocopies of any corresponding documents, such as complaints or board actions.

Moral Turpitude includes but is not limited to the following: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Fabricating and Presenting False Public Claim, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale & Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with Transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting and Soliciting Prostitution.

Name: William D. Ross M.D. License Number: 23599

Signature: William Ross M.D.

CONFIDENTIAL

Physical/Mental Health and Substance Abuse

1.	**Since your last renewal have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?**	[redacted]
2.	**Are you now or since your last renewal been addicted to or abused any chemical substance including alcohol (excluding tobacco and caffeine)?**	
3.	**Are you now being treated or since your last renewal have you been treated or evaluated for a drug or alcohol addiction or participated in a rehabilitation program?** *If in a confidential program in another state see explanation below.	
4.	**Since your last renewal have you been criminally charged with or investigated by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility for inappropriate contact with a patient or patients?**	
5.	**Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1) behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice?**	

Ability to practice medicine is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other healthcare providers, with or without the use of aids or devices, such as a voice amplifier; 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 chronic and/or uncorrected orthopedic, visual, speech, or hearing impairments, epilepsy, multiple sclerosis, behavioral health illness, dementia, drug addiction and alcoholism.

In the event you answer YES to any of the above questions, you must file with the renewal a detailed written narrative statement concerning the above matter(s), including the name and address of healthcare providers, physicians, preceptors, hospitals/rehabilitation centers, etc. where you were counseled/treated. You must also have a copy of your history and physical examinations, consultation reports, discharge summaries from all hospitals/rehabilitation centers and a statement from your attending physicians or treating therapists setting forth your diagnosis, prognosis and recommendations for continuing care, treatment, supervision and a statement as to whether there is anything that would prevent you from safely practicing any type of medicine. **Statement from attending physician must come with your renewal.** Treatment records must be sent directly to the board.

If you are currently participating or have participated pursuant to a CONFIDENTIAL AGREEMENT OR ORDER in a program for the treatment and rehabilitation of doctors of medicine impaired by alcohol, drug abuse or for other issues YOU MUST SUBMIT A NARRATIVE OF CIRCUMSTANCES WITH YOUR RENEWAL AND REQUEST THE FOLLOWING DOCUMENTATION BE SENT DIRECTLY TO THE ARIZONA MEDICAL BOARD'S PHYSICIAN HEALTH PROGRAM.

• Evaluation/Treatment records • Psychiatric/Psychological records • Compliance reports from state monitoring programs

Please note: All documents requested above must be sent directly from the primary source to the Arizona Medical Board's Physician Health Program Department from the primary source and will not be accepted if submitted by the applicant.
FAILURE TO PROPERLY ANSWER THESE QUESTIONS OR DISCLOSE ALCOHOL, SUBSTANCE ABUSE OR OTHER ISSUES CAN RESULT IN BOARD DISCIPLINARY ACTION.
If you have any questions, please contact the Board's Physician Health Program at (480) 551-2716 or (877) 255-2212.

Name: William Ross MD. License Number: 23599

Signature: William D. Ross M.D.

William D. Ramos, M.D., Ltd.

DBA: A-Z Women's Center
1670 East Flamingo Road Suite C.
Las Vegas, NV 89119
Tel: (702) 892-0660
Fax: (702) 650-0549

8/2/2008

Arizona Medical Board
9545 E. Doubletree Ranch Rd.
Scottsdale, AZ 85258

Dear Sirs:

The Nevada State Board of Medical Examiners has opened an investigation [redacted]

The State Board of Nevada is doing its diligent responsibility and has scheduled a hearing into the matter for Sept. 16, 2008. To date, there have been no charges, hearings, or findings.

Very Sincerely,

William D. Ramos, M.D.
President

ARIZONA MEDICAL BOARD
2006 BIENNIAL MD LICENSE RENEWAL APPLICATION

RCK-1087

AZ MD Lic#: 23599 William D. Ramos, MD **Renewal Fee: $500 /$850** (if postmarked after **10/15/2006**)

CURRENT INFORMATION Please review and make corrections as necessary ™	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS PUBLIC ADDRESS & PHONE NUMBER 1670 E Flamingo Rd Ste C Las Vegas NV 89119-5120 **Phone #:** (702) 892-0660 **Fax #:** (702) 650-0549 **E-Mail:** [redacted]	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS** **Phone #:** **Fax #:** **E-Mail:**
MAILING ADDRESS 1670 E Flamingo Rd Ste C Las Vegas NV 89119-5120	**MAILING ADDRESS**
HOME ADDRESS [redacted] **Phone #:** [redacted] **Fax #:** **E-Mail:** **Mobile #:**	**HOME ADDRESS** **Phone #:** **Fax #:** **E-Mail:** **Mobile #:** (Optional)

RECEIVED BY:
AUG 21 2006
ARIZONA MEDICAL BOARD
BUSINESS OPERATIONS

AMERICAN BOARD OF MEDICAL SPECIALTY CERTIFICATIONS AND FIELDS OF PRACTICE:

Only certifications from ABMS will be shown in your profile on the website. Please indicate expiration date or lifetime certificate.

	Certified?	Practicing?
PTH	Y	Y
OBG	Y	Y
FOP	Y	N

Make corrections if necessary INTIALS REQUIRED

	Certified?	Practicing?	Expiration Date	Initials Required
			N/A	WR
			N/A	WR
			N/A	WR

If the above fields are not verified by your initials the ABMS certification will be removed from your profile on the website.

I REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:

☐ INACTIVE STATUS: Please inactivate my Arizona license. My signature serves to certify the following: That I am not presently under investigation by the board, the board has not commenced any disciplinary proceedings against me, and I am totally retired from the practice of medicine in this state or any state, territory, or district of the United States or foreign country. I understand that once inactive status is granted, the board will waive the annual renewal fees and requirements for CME. I further understand that I may not engage in the practice of medicine, hold registration with the Drug Enforcement Administration, or write prescriptions as long as my license is classified as inactive. I further understand that if I request reactivation of my license, I may be required to pass the SPEX examination and that the board may require any combination of physical examination, psychiatric, psychological evaluations and interviews it deems necessary to determine my ability to safely engage in the practice of medicine.

☐ CANCELLATION: Please cancel my Arizona license. My signature serves to certify the following: That I am not presently under investigation by the board; the board has not commenced any disciplinary proceedings against me; and that I am requesting cancellation for the reason that I am no longer practicing medicine in the State of Arizona.

CONTINUED ON BACK →

1. Since your last renewal have you had any application for any professional license refused or denied by any licensing authority?	YES ☐ NO ☒
2. Since your last renewal have you been refused or denied the privilege of taking an examination required for any professional licensure?	YES ☐ NO ☒
3. Since your last renewal have you voluntarily surrendered any healthcare license?	YES ☐ NO ☒
4. Since your last renewal have you had any healthcare license revoked?	YES ☐ NO ☒
5. Other than Arizona have you been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license, been sanctioned by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐ NO ☒
6. Since your last renewal have your privileges been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility?	YES ☐ NO ☒
7. Other than Arizona has disciplinary action been taken against you by any licensing agency with regard to any professional license? Including but not limited to restricted, terminated, voluntarily or involuntarily resigned or withdrawn.	YES ☐ NO ☒
8. Since your last renewal have you had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied or have you surrendered or given up in lieu of action?	YES ☐ NO ☒
9. Since your last renewal have you been charged with or convicted, pardoned or had a record expunged or vacated of a felony, misdemeanor involving moral turpitude? (see explanation below) A "yes" answer is required even if you entered a diversion program.	YES ☐ NO ☒
10. Since your last renewal have you been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	YES ☐ NO ☒
11. Since your last renewal have you been court martialed or discharged other than honorably from the armed service?	YES ☐ NO ☒
12. Since your last renewal have you been terminated from a healthcare position with a city, county, or state government or the Federal government?	YES ☐ NO ☒
13. Since your last renewal have you been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government?	YES ☐ NO ☒

Note: ***In the event the response to any of the questions numbered 1 through 13 is "YES",*** the physician must file with the renewal a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings; and the disposition of such matters. IN ADDITION, the applicant must submit photocopies of any corresponding documents, such as patient records, complaints or board actions.

Moral Turpitude includes but is not limited to the following: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Fabricating and Presenting False Public Claim, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale & Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with Transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting and Soliciting Prostitution.

QUESTIONS CONTINUED ON NEXT PAGE →

CONFIDENTIAL

Physical/Mental Health and Substance Abuse

1. Since your last renewal have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?	[redacted]
2. Are you now or since your last renewal been addicted to or abused any chemical substance including alcohol (excluding tobacco and caffeine)?	
3. Are you now being treated or since your last renewal have you been treated or evaluated for a drug or alcohol addiction or participated in a rehabilitation program? *If in a confidential program in another state see explanation below.	
4. Since your last renewal have you been criminally charged with or investigated by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility for inappropriate contact with a patient or patients?	
5. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1) behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice? See below for definition of ability to practice medicine.	

In the event you answer YES to any of the above questions, you must file with the renewal a detailed written narrative statement concerning the above matter(s), including the name and address of healthcare providers, physicians, preceptors, hospitals/rehabilitation centers, etc. where you were counseled/treated. You must also have a copy of your history and physical examinations, consultation reports, discharge summaries from all hospitals/rehabilitation centers and a statement from your attending physicians or treating therapists setting forth your diagnosis, prognosis and recommendations for continuing care, treatment, supervision and a statement as to whether there is anything that would prevent you from safely practicing any type of medicine. This must be sent directly to the board.

If you are currently participating or have participated pursuant to a CONFIDENTIAL AGREEMENT OR ORDER in a program for the treatment and rehabilitation of doctors of medicine impaired by alcohol, drug abuse or for other issues YOU MUST SUBMIT A NARRATIVE OF CIRCUMSTANCES WITH YOUR APPLICATION AND REQUEST THE FOLLOWING DOCUMENTATION BE SENT DIRECTLY TO THE ARIZONA MEDICAL BOARD'S PHYSICIAN HEALTH PROGRAM.

• Evaluation/Treatment records • Psychiatric/Psychological records • Compliance reports from state monitoring programs

Please note: All documents requested above must be sent directly from the primary source to the Arizona Medical Board's Physician Health Program Department from the primary source and will not be accepted if submitted by the applicant. FAILURE TO PROPERLY ANSWER THESE QUESTIONS OR DISCLOSE ALCOHOL, SUBSTANCE ABUSE OR OTHER ISSUES CAN RESULT IN BOARD DISCIPLINARY ACTION.
If you have any questions, please contact the Board's Physician Health Program at (480) 551-2716 or (877) 255-2212.

Ability to practice medicine is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other healthcare providers, with or without the use of aids or devices, such as a voice amplifier; 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 chronic and/or uncorrected orthopedic, visual, speech, or hearing impairments, epilepsy, multiple sclerosis, behavioral health illness, dementia, drug addiction and alcoholism.

I hereby certify, under penalty of perjury, I am a U.S. Citizen or a qualified/registered alien and that all information on this form is currently accurate. I also certify that during calendar years 2004 and 2005, I have completed a minimum of 40 credit hours of continuing medical education as required by A.R.S. §32-1434 and A.A.C. § R4-16-101.

William Ramos M.D. 8/17/06

Signature of Licensee (Signature stamp will not be accepted) Date

23599 William D. Ramos, MD

ARIZONA MEDICAL BOARD
2004 BIENNIAL MD LICENSE RENEWAL APPLICATION

5265

AZ MD Lic#: 23599 William D. Ramos, MD Renewal Fee: **$500** **$850** (if postmarked after 10/15/2004)

CURRENT INFORMATION Please review and make corrections as necessary →	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER** 1670 E Flamingo Rd Ste C Las Vegas NV 89119-5120 **Phone #:** (702) 892-0660 **Fax #:** (702) 650-0549 **E-Mail:** [redacted]	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS** **Phone #:** **Fax #:** **E-Mail:**
MAILING ADDRESS 1670 E Flamingo Rd Ste C Las Vegas NV 89119-5120	**MAILING ADDRESS**
HOME ADDRESS [redacted] **Phone #:** [redacted] **Fax #:** **E-Mail:**	**HOME ADDRESS** **Phone #:** **Fax #:** **E-Mail:** **Cell Phone #:** (Optional)

RECEIVED JUL 23 2004 By

AMERICAN BOARD CERTIFICATIONS AND FIELDS OF PRACTICE: *Select from the attached list of Self-Designated "Field of Practice" Codes*

	Certified?	Practicing?
PTH	Y	Y
OBG	Y	Y
FOP	Y	N

Make corrections if necessary

	Certified?	Practicing?
GYN	YES	YES

I REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:

☐ **INACTIVE STATUS**: Please inactivate my Arizona license. My signature below serves to certify the following: That I am not presently under investigation by the board, the board has not commenced any disciplinary proceedings against me, and I am totally retired from the practice of medicine in this state or any state, territory, or district of the United States or foreign country. I understand that once inactive status is granted, the board will waive the annual renewal fees and requirements for CME. I further understand that I may not engage in the practice of medicine, hold registration with the Drug Enforcement Administration, or write prescriptions as long as my license is classified as inactive. I further understand that if I request reactivation of my license, I may be required to pass the SPEX examination and that the board may require any combination of physical examination, psychiatric, psychological evaluations and interviews it deems necessary to determine my ability to safely engage in the practice of medicine.

☐ **CANCELLATION**: Please cancel my Arizona license. My signature below serves to certify the following: That I am not presently under investigation by the board; the board has not commenced any disciplinary proceedings against me; and that I am requesting cancellation for the reason that I am no longer practicing medicine in the State of Arizona.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Other than in Arizona, are you currently under investigation by any medical board or peer review body? ☐ Yes ☒ No
2. Other than in Arizona, since your last renewal have you had a medical license disciplined resulting in revocation, suspension, limitation, restriction, probation, voluntary surrender or cancellation during an investigation? **(see instructions on back)** ☐ Yes ☒ No
3. Since your last renewal have you had hospital privileges revoked, denied, suspended or restricted? **(see instructions)** ☐ Yes ☒ No
4. Since your last renewal, have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by any agency of the federal or state government? **(see instructions)** ☐ Yes ☒ No
5. Since your last renewal, have you had the authority to prescribe, dispense or administer medications limited, restricted, modified, denied, surrendered or revoked by a federal or state agency? **(see instructions)** ☐ Yes ☒ No
6. Within the last 5 years, have you had or do you have a medical condition that impairs or limits your ability to safely practice medicine? **(see instructions)** [redacted]
7. Do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication?
8. Have you consumed intoxicating beverages resulting in your present ability to exercise the judgment and skills of a medical professional, being impaired or limited
9. Have you been denied a license in another state? If yes, ☐ Yes ☒ No
   State_____ Date of Denial_____ Reason for Denial_____
10. Since your last renewal, have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state? ☐ Yes ☒ No
    If yes, please attach an explanation and applicable court docket. See instructions on back.
11. Since your last renewal, has a malpractice lawsuit resulted in a settlement or judgment against you? ☐ Yes ☒ No

If the answer is "yes" to any of the above questions, please provide a complete written explanation to include dates. If malpractice cases are reported, please include: a copy of the complaint and settlement agreement/judgment.

I hereby certify, under penalty of perjury, that all information on this form is currently accurate. I also certify that during calendar years 2002 and 2003, I have completed a minimum of 40 credit hours of continuing medical education as required by A.R.S. §32-1434 and A.A.C. § R4-16-101.

William D. Ramos M.D. 7/20/2004

Signature of Licensee (Signature stamp will not be accepted) Date

NOTE: DO NOT SUBMIT CME DOCUMENTATION UNLESS A CME AUDIT FORM IS INCLUDED WITH YOUR RENEWAL PACKET

ARIZONA STATE BOARD OF MEDICAL EXAMINERS
2002 BIENNIAL MD LICENSE RENEWAL APPLICATION

4001

AZ MD Lic#: 23599 William D. Ramos, MD Renewal Fee: **$450** **$800** (if postmarked after **10/15/2002**)

CURRENT INFORMATION Please review and make corrections as necessary ⇨	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS 1670 E Flamingo Rd Ste C Las Vegas NV 89119-5120	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS**
Phone #: (702) 892-0660 **Fax #:** (702) 650-0549 **E-Mail:** [redacted]	**Phone #:** **Fax #:** **E-Mail:**
MAILING ADDRESS 1670 E Flamingo Rd Ste C Las Vegas NV 89119-5120	**MAILING ADDRESS**
HOME ADDRESS [redacted]	**HOME ADDRESS**
Phone #: [redacted] **Fax #:** **E-Mail:**	**Phone #:** **Fax #:** **E-Mail:** **Cell Phone #:** (Optional)

RECEIVED
AUG 29 2002
By

AMERICAN BOARD CERTIFICATIONS AND FIELDS OF PRACTICE: *Select from the attached list of Self-Designated "Field of Practice" Codes*

	Certified?	Practicing?
PTH	Y	Y
OBG	Y	N
GYN	N	Y

Make corrections if necessary

	Certified?	Practicing?
FOP	Y	N
PTH	Y	Y
OBG [redacted]	Y	Y

I REQUEST THE FOLLOWING CHANGE IN LICENSE STATUS:

☐ **INACTIVE STATUS**: Please inactivate my Arizona license. My signature below serves to certify the following: That I am not presently under investigation by the board, the board has not commenced any disciplinary proceeding against me, and I am totally retired from the practice of medicine in this state or any state, territory, or district of the United States or foreign country. I understand that once inactive status is granted, BOMEX will waive the annual renewal fees and requirements for CME. I further understand that I may not engage in the practice of medicine, hold registration with the Drug Enforcement Administration, or write prescriptions as long as my license is classified as inactive. I further understand that if request reactivation of my license, I may be required to pass the SPEX examination and that the Board may require any combination of physical examination, psychiatric, psychological evaluations and interviews it deems necessary to determine my ability to safely engage in the practice of medicine.

☐ **CANCELLATION**: Please cancel my Arizona license. My signature below serves to certify the following: That I am not presently under investigation by the Board; the Board has not commenced any disciplinary proceedings against me; and that I am requesting cancellation for the reason that I am no longer practicing medicine in the State of Arizona.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Other than in Arizona, are you currently under investigation by any medical board or peer review body? ☐ Yes ☒ No
2. Other than in Arizona, since your last renewal have you had a medical license disciplined resulting in revocation, suspension, limitation, restriction, probation, voluntary surrender or cancellation during an investigation? (**see instructions on back**) ☐ Yes ☒ No
3. Since your last renewal have you had hospital privileges revoked, denied, suspended or restricted? (**see instructions**) ☐ Yes ☒ No
4. Since your last renewal, have you been subjected to any regulatory disciplinary action, including censure, practice restriction, suspension, sanction, or removal from practice, imposed by any agency of the federal or state government? (**see instructions**) ☐ Yes ☒ No
5. Since your last renewal, have you had the authority to prescribe, dispense or administer medications limited, restricted, modified, denied, surrendered or revoked by a federal or state agency? (**see instructions**) ☐ Yes ☒ No
6. Within the last 5 years, have you had or do you have a medical condition that impairs or limits your ability to safely practice medicine? (**see instructions**) [redacted]
7. Do you engage in the illegal use of any controlled substance, habit-forming drug, or prescription medication? [redacted]
8. Have you consumed intoxicating beverages resulting in your present ability to exercise the judgment and skills of a medical professional, being impaired or limited? [redacted]
9. Have you been denied a license in another state? If yes, ☐ Yes ☒ No
   State_____ Date of Denial_____ Reason for Denial_____
10. Since your last renewal, have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state? ☐ Yes ☒ No
    If yes, please attach an explanation and applicable court docket. See instructions on back.
11. Since your last renewal, has a malpractice matter resulted in a settlement or judgment against you? ☒ Yes ☐ No

TO INV

If the answer is "yes" to any of the above questions, please provide a complete written explanation. If malpractice cases are reported, please include: the case number, venue, plaintiff name, and attorney names/addresses/phone numbers. In addition, for all malpractice settlements and judgments, a copy of the National Practitioner Data Bank (NPDB) report should be submitted to the board. You may obtain this report by contacting the NPDB at (800) 767-6732 or on-line at www.npdb-hipdb.com.

I hereby certify, under penalty of perjury, that all information on this form is currently accurate. I also certify that during calendar years 2000 and 2001, I have completed a minimum of 40 credit hours of continuing medical education as required by A.R.S. §32-1434 and A.A.C. § R4-16-101.

William D. Ramos M.D.
Signature of Licensee (Signature stamp will not be accepted)

8/24/2002
Date

NOTE: DO NOT SUBMIT CME DOCUMENTATION UNLESS A CME AUDIT FORM IS INCLUDED WITH YOUR RENEWAL PACKET

"A"