RECEIVED
CASH SECTION
OCT 12 2012
Div. of Professional Regulation

036131869

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE AND/OR EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

A. SEE REFERENCE SHEET, CHART I, OR INSTRUCTIONS PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
PARKER	036	ENDORSEMENT	$ 300

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- ☒ This is the first time I have made application for this profession in Illinois.
- ☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- ☐ Other: _____
- ☐ My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
- ☐ I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.

PART II: Applicant Identifying Information–You must notify the Department of Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST FIRST MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
PARKER WILLIE JAMES	MD	[redacted]

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY
[redacted]

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY
same as above

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)
PARKER

7. MOTHER'S MAIDEN NAME
PARKER

8. PLACE OF BIRTH CITY STATE/COUNTRY
[redacted]

9. DATE OF BIRTH
[redacted]
Month Day Year

[redacted]
☐ Female
☒ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
Work: [redacted] (Area Code)
Home [redacted] (Area Code)
Fax: (____) ____-____ (Area Code)
Fax: (____) ____-____ (Area Code)

12. PREFERRED e-MAIL ADDRESS(ES) (if available)
[redacted]

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.

NAME (Last, First, MI): Parker, Willie J

SS#:

Profession: Medicine

PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)

1 2 3 4 5 6 7 8 9 10 11 (12)

Graduated High School? ☒ Yes ☐ No

Received OR G.E.D.? ☐ Yes ☐ No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION
Ensley High School	Birmingham AL	06 / 1981 (Month / Year)

5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 (5) 6 7 8

Graduated? ☒ Yes ☐ No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED
Berea College	Berea, KY, USA	08/81	05/86	B.A.
Harvard School Public Health	Boston, MA	06/97	06/98	M'PH
Univ. of Michigan	Ann Arbor, MI	07/06	12/07	M.Sc.
Univ of Iowa	Iowa City, IA	06/86	05/90	M.D.

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
University of Cincinnati	Cincinnati OH	07/90	06/94	☑ Yes ☐ No
Univ of Michigan	Ann Arbor, MI	07/06	06/08	☑ Yes ☐ No
University of CA-SF	San Francisco, CA	07/00	06/01	☑ Yes ☐ No
Centers for Disease Control	Atlanta, GA	07/99	06/00	☐ Yes ☑ No
				☐ Yes ☐ No

NAME (Last, First, MI): Parker, Willie J

SS#: [redacted]

Profession: Medicine

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure				
Iowa	Medicine	28574	3/19/92	Inactive
State of Current Licensure where you most recently have been practicing.	Pennsylvania	MD441490	11/9/10	active
Other States of Licensure				
New Jersey	Medical Doctor	25MA09111500	5/18/12	Active
Washington DC	Medicine	MD037446	6/30/08	active
Maryland	Medicine	D69574	07/15/09	active
Virginia	Medicine + Surgery	0101246274	8/13/09	Active
Ohio	Doctor of Medicine	35.063458	5/29/92	Inactive

(If additional space is needed, attach a separate sheet.)

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
~~N/A~~			(Passed, Failed, Absent)
FLEX Licensing Exam	Iowa	06/1990	Passed

(If additional space is needed, attach a separate sheet.)

NAME (Last, First, MI): Parker, Willie, J

SS#:

Profession: Medicine

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure continued				
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				
MICHIGAN	Medicine	4301087686	5/28/06	lapsed
CALIFORNIA	Physician + Surgeon	A53102	5/25/94	lapsed
HAWAII	Physician	MD-11733	10/31/04	inactive
MISSISSIPPI	Physician	22028	5/23/12	active
ALABAMA	Physician	MD.3166	4/18/12	active

(If additional space is needed, attach a separate sheet.)

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
			(Passed, Failed, Absent)

(If additional space is needed, attach a separate sheet.)

PART VI: Personal History Information *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		X
2. Have you been convicted of a felony?		X
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		X
4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		X
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		X
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		X

PART VII: Examination Coding Information ***(This part is for examination applicants only)***

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes. [ ][ ] [ ][ ] [ ][ ] [ ][ ] [ ][ ] [ ][ ]

b) CHART III - Select the examination site you desire and enter Test Center Code: [ ][ ][ ][ ]

c) CHART IV - Find your School of Graduation and enter school code: [ ][ ][ ][ ][ ]

d) Record the number of times you have taken this exam in Illinois or any other state: [ ][ ]

PART VIII: Child Support and/or Student Loan Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? Yes ☐ No ☒
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes ☐ No ☒

PART IX: Certifying Statement

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

[redacted] 10/1/12

Signature of Applicant Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

NAME (Last, First, MI): Parker, Willie J,

SS#: [redacted]

Profession: Medicine

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

HEALTH CARE WORKERS CHARGED WITH *OR* CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME LAST FIRST MIDDLE

PARKER WILLIE J

3. PROFESSIONAL LICENSE NUMBER (if any)

---·------

2. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

4. SOCIAL SECURITY NUMBER

[redacted]

Pursuant to 20ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding convictions pertaining to certain offenses. **Please check applicable profession.**

- ☐ Advanced Practice Nurses
- ☐ Audiologists
- ☐ Clinical Psychologists
- ☐ Clinical Social Workers
- ☐ Dental Hygienists
- ☐ Dentists
- ☐ Occupational Therapists
- ☐ Optometrists
- ☐ Pharmacists
- ☐ Podiatrists
- ☐ Physical Therapists
- ☐ Physician Assistants
- ☑ Physicians (036)
- ☐ Registered Nurses
- ☐ Speech Pathologists

In order for your application to be evaluated, you must respond to each of the following questions:

		Yes	No
1)	Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *	☐	☒
2)	Are you currently charged with or have you been convicted of a criminal battery against any patient *in the course of patient care or treatment*, including any offense based on sexual conduct or sexual penetration?	☐	☒
3)	Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *	☐	☒

*If **YES** to any of the above, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

[redacted]

Signature of Applicant

Date 10/1/12

Section III

Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of Iowa College of Medicine

Complete Address:

Street Address: 1216 MERF

City: Iowa City **State:** IA **ZIP Code (Postal Code):** 52242

If name of institution was different when this individual attended, please note this name below:

Premedical Education:

Years of education required for admission to your medical school: 4

Credential/degree presented by the applicant for admission to your medical school: B.A.

Enrollment and Participation: Our records indicate that Parker, Willie James
(type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 164 weeks of medical education on the following dates (mm/dd/yy):

From 06 (Month) , 09 (Date) , 86 (Year) **To** 05 (Month) , 04 (Date) , 90 (Year)

This individual (check one):

Was awarded the degree of Doctor of Medicine on 05 (Month) , 04 (Date) , 90 (Year)

Was NOT awarded a degree because:
(please explain - attach additional pages if necessary)

Certification: By my signature, I, Larissa Heimer (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

SEAL VERIFIED — Affix Institutional Seal Here. If no seal is available, this form must be notarized.

Signature: Larissa Heimer

Title: Student Programs & Records

Date of Signature: 6-9-08

Phone: [redacted]

Email: [redacted]

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response YES ☐ NO ☒

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify: _____

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Response YES ☐ NO ☒

   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify reason: _____

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
   Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE

Parker, Willie James

3. ADDRESS STREET, CITY, STATE, ZIP CODE

[redacted]

4. DATE OF BIRTH

[redacted]

Month Day Year

5. SOCIAL SECURITY NUMBER

[redacted]

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

	Profession Code
☑ Permanent Physician License	036
☐ Temporary Physician Training License	125
☐ Chiropractic Physician License	038

6. MAIDEN OR GIVEN SURNAME

Parker

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.

A. NAME OF BUSINESS / INSTITUTION

Self employed, Independent Contractor

JOB TITLE

Independent Contractor

ADDRESS STREET, CITY, STATE, ZIP CODE

2819 5th Street NE Wash DC (home)

DESCRIPTION OF DUTIES PERFORMED

Provision of family planning services (female contraception and counseling) as well as abortion services in PA, DC, AL, and MS.

DATE OF EMPLOYMENT/ATTENDANCE

From 07/15/2011 (Month Day Year)

To present (Month Day Year)

HOURS WORKED PER WEEK

32

TYPE OF EMPLOYMENT

☒ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

1 year, 3 months

B. NAME OF BUSINESS / INSTITUTION

Planned Parenthood, Metro Wash, DC

JOB TITLE

Medical Director / Indep Contractor

ADDRESS STREET, CITY, STATE, ZIP CODE

1108 16th Street, NW Wash, DC 20036

DESCRIPTION OF DUTIES PERFORMED

Medical leadership + Clinical supervision of 5 clinic affiliate Director of gynecology, abortion services, laboratory director, Also independent contractor for abortion services.

DATE OF EMPLOYMENT/ATTENDANCE

From 06/15/2009 (Month Day Year)

To 07/15/2011 (Month Day Year)

HOURS WORKED PER WEEK

40

TYPE OF EMPLOYMENT

☐ Full-time ☒ Part-time

TOTAL TIME WORKED (Year/Month)

2 years, 1 month

NAME (Last, First, MI): Parker, Willie

SS#:

Profession: Medicine

C. NAME OF BUSINESS / INSTITUTION
Washington Hospital Center

JOB TITLE
Director, Family Planning Services

ADDRESS STREET, CITY, STATE, ZIP CODE
110 Irving Street, NW Wash DC 20010

DESCRIPTION OF DUTIES PERFORMED
Director of Family Planning and abortion services. Resident education in obstetrics, gynecology & ambulatory women's health.
5/31 - 6/14/09 (vacation)

DATE OF EMPLOYMENT/ATTENDANCE
From 08/01/2008 (Month/Day/Year)
To 05/30/2009 (Month/Day/Year)

HOURS WORKED PER WEEK
40

TYPE OF EMPLOYMENT
☑ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
9 months

D. NAME OF BUSINESS / INSTITUTION
University of Michigan Hospitals

JOB TITLE
Clinical Instructor

ADDRESS STREET, CITY, STATE, ZIP CODE
L4000 WH 1500 E. Medical Ctr Ann Arbor MI 48109

DESCRIPTION OF DUTIES PERFORMED
Resident education, FULL-scope obstetrics and gynecology, family planning, abortion services
7/1 - 7/31/2008 (vacation relocation)

DATE OF EMPLOYMENT/ATTENDANCE
From 07/01/2006 (Month/Day/Year)
To 06/30/2008 (Month/Day/Year)

HOURS WORKED PER WEEK
40

TYPE OF EMPLOYMENT
☑ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)
2 years

E. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE
From ___/___/_____ (Month/Day/Year)
To ___/___/_____ (Month/Day/Year)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT
☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

F. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE
From ___/___/_____ (Month/Day/Year)
To ___/___/_____ (Month/Day/Year)

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT
☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Health Professional
Licensing Administration

Dear Sir or Madam:

This is to certify the following information, maintained in the records of the Department of Health Board of MEDICINE, for the below referenced Health Care Practitioner:

Name:	WILLIE J PARKER
License Type:	MEDICINE AND SURGERY
License Number:	MD037446
Original Licensure Date:	06/30/2008
Expiration Date:	12/31/2012
Obtained By:	Waiver of Examination
License Status:	Active
Other:	BEREA COLLEGE 05/01/1986

HARVARD SCHOOL OF PUBLOC HEALTH 06/01/1998
UNIVERSITY OF IOWA COLLEGE OF MEDICINE 05/01/1990

Unless stated below, there is no disciplinary action pending nor has any been taken.
NOTE: _____ If this blank has been checked, disciplinary action has been taken.
(See attached copies.)

[redacted]
Jacqueline A. Watson, DO, MBA
Executive Director
D.C. Board of Medicine

SEAL

Certified By: Alma White DOH
Title: Health Licensing Specialist
Date: December 5, 2012

CELEBRATING 125 YEARS

STATE OF IOWA
IOWA BOARD OF MEDICINE

MARK BOWDEN
EXECUTIVE DIRECTOR

October 02, 2012

Verification of Licensure

Illinois Department of Financial and Professional Regulation
320 W Washington, 3rd Fl
Springfield, IL 62786

This is to certify that the records of the Iowa Board of Medicine indicate the following information regarding this physician.

NAME:	Willie James Parker, MD
DATE OF BIRTH:	[redacted]
LICENSE NUMBER:	28574
LICENSE TYPE:	Permanent
ISSUE DATE:	03/19/1992
EXPIRATION DATE:	10/01/1994
HOW OBTAINED:	FLEX
STATUS:	Inactive
DISCIPLINARY ACTION:	No
HISTORY OF INVESTIGATION:	*See below*

RECEIVED
OCT 0 2 2012
IDPR-MEDICAL UNIT

This license information was last updated on: 10/02/2012

The above format is prepared for all physicians regulated by this board. All physicians are considered in good standing unless otherwise noted. **If disciplinary action has been indicated or if a history of investigation exists, a copy of that information will be provided to your office in a separate mailing within ten business days.**

Sincerely,

[redacted]

RECEIVED ELECTRONICALLY

Rachel Davis
Licensing Assistant

Section IV

Graduate Medical Education Training

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5098

Verification of Postgraduate Medical Education

Institution: University of Cincinnati Medical Center
Address: Department of OB/GYN
Cincinnati, OH 45267-0526

Attention: **Program Director**
Affiliated University: University of Cincinnati

Verification For:

Name: Parker, Willie James
DOB: [redacted]
Individual's Name on Record (if different from above): ____

Program Participation:

Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 1-4
☐ Internship
☒ Residency
☐ Chief Residency
☐ Fellowship
☐ Research
Specialty/Subspecialty: OB/GYN
From: 7/1/90 To: 6/30/94
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: ____
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research
Specialty/Subspecialty: ____
From: __/__/____ To: __/__/____
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: ____
☐ Internship
☐ Residency
☐ Chief Residency
☐ Fellowship
☐ Research
Specialty/Subspecialty: ____
From: __/__/____ To: __/__/____
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

____

____

Certification:

ELECTRONIC SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Arthur Ollendorff Signature: [redacted]
Title: Residency Program Director Date of Signature: 10/15/08
Tel: 5[redacted]

Rev. 09/07/05 Packet ID: 91393 Request ID: 19361582 IFM CODE [12174]

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)
Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: University of California, San Francisco
Address: Division of Preventive Medicine and Public Health
San Francisco, California 94105

Attention: **Program Director**
Affiliated University: University of California (San Francisco) School of Medicine

Verification For:

Name: **Parker, Willie James**

DOB: [redacted]

Individual's Name on Record (if different from above): _____

Program Participation:

Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 6
☐Internship ☒Residency ☐Chief Residency ☐Fellowship ☐Research
Specialty/Subspecialty: General Preventive Medicine & Public Health
From: 07/01/2000 To: 06/30/2001
Successfully Completed?: ☒Yes ☐No ☐In Progress
Accredited by: ☑ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

PGY: _____
☐Internship ☐Residency ☐Chief Residency ☐Fellowship ☐Research
Specialty/Subspecialty: _____
From: ___/___/___ To: ___/___/___
Successfully Completed?: ☐Yes ☐No ☐In Progress
Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

PGY: _____
☐Internship ☐Residency ☐Chief Residency ☐Fellowship ☐Research
Specialty/Subspecialty: _____
From: ___/___/___ To: ___/___/___
Successfully Completed?: ☐Yes ☐No ☐In Progress
Accredited by: ☐ACGME ☐AOA ☐LCGME ☐RSC ☐CFPC ☐RCPSC ☐APPAP ☐None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐Yes ☒No
2. Was this individual ever placed on probation? ☐Yes ☒No
3. Was this individual ever disciplined or placed under investigation? ☐Yes ☒No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐Yes ☒No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐Yes ☒No

Please explain any "Yes" response from above:

ELECTRONICALLY SEAL VERIFIED

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: George W. Rutherford, M.D. Signature: [redacted]

Title: Program Director Date of Signature: June 12, 2009

Tel: [redacted]

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: University of Michigan Medical School
Address: Department of OB/GYN
Ann Arbor, MI 48109

Attention: **Program Director**
Affiliated University: ____

Verification For:

Name: Parker, Willie James
DOB: 1[redacted]
Individual's Name on Record (if different from above): ____

Program Participation:

Important:
Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: VII
☐ Internship ☐ Residency ☐ Chief Residency ☒ Fellowship ☐ Research
Specialty/Subspecialty: Family Planning
From: 07/01/2008 To: 06/30/2008
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☒ None

PGY: ____
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: ____
From: __/__/____ To: __/__/____
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: ____
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: ____
From: __/__/____ To: __/__/____
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

____

____

Certification:

ELECTRONIC SEAL VERIFIED

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: Lisa L. Harris, MD, PhD
Signature: [redacted]
Title: Program Director
Date of Signature: 10/8/2008
Tel: [redacted]

Rev. 09/07/05 Packet ID: 91393 Request ID: 19361582 IFM CODE [16923]

Section V

Examination History/Score Transcripts

Federation of STATE MEDICAL BOARDS

[redacted]RATION LICENSING EX[redacted]NATION (FLEX)
Certified Transcript of Scores

This Transcript was prepared by the Federation of State Medical Boards

Federation Credentials Verification Service
ATTN: FCVS
Euless, TX 76039

Packet ID: [redacted]

EXAMINEE: Parker, Willie James
USMLE ID#: [redacted]
DOB:
ALTERNATE NAME(S):

It is certified that the above named physician took the Federation Licensing Examination on the date(s) entered below for the State Medical Licensing Board(s) listed and obtained the following scores:

FIN: [redacted]

Date of Certification: 10/12/2012

Date of Exam	State Exam Taken For	State ID	Comp 1	Comp 2
6/12/90	IOWA	[redacted]		

COMPONENT 1 of FLEX is designed to evaluate measurable aspects of the knowledge and understanding of basic and clinical sciences, with specific emphasis on principles and mechanisms underlying disease and modes of therapy.

COMPONENT 2 of FLEX is designed to assess the additional cognitive abilities required of physicians who will ultimately assume independent responsibilities for the general health care of patients.

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2382 FAX (916) 263-2944
www.mbc.ca.gov

Parker, Willie J.

October 02, 2012

TO WHOM IT MAY CONCERN:

This is to certify that on the date of this letter the records of the Medical Board of California (Board) indicate the following information:

PHYSICIAN:	WILLIE JAMES PARKER
LICENSE NUMBER:	A53102
ISSUED:	May 25, 1994
EXAM TYPE:	A Written Examination
EXPIRATION DATE:	October 31, 2009
STATUS:	DELINQUENT
BOARD DISCIPLINE:	No

RECEIVED
OCT 0 2 2012
IDPR-MEDICAL UNIT

This license information was last updated on: 10/01/2012

Further public records pertaining to the above licensee may be available from the Board's Web site at www.mbc.ca.gov.

[redacted]

Curtis J. Worden
Chief of Licensing

RECEIVED ELECTRONICALLY

TELEPHONE: (601) 987-3079

FAX: (601) 987-4159

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

VERIFICATION OF MEDICAL LICENSURE

October 02, 2012

This is to certify that the records of the Mississippi State Board of Medical Licensure indicate the following information:

Physician Name: **Willie James Parker** Degree: **M.D.**

Date of Birth: [redacted]

Primary Practice Location: **777 Appletree Street**
7th Floor
Philadelphia, PA 19106

MD/DO School: **University of Iowa Roy J & Lucill** Year of Graduation: **1990**

Specialty: **OBSTETRICS AND GYNECOLOGY (Not Primary Source Verified)**

License Number: **22028**
Issue Date: **May 23, 2012**
Expiration Date: **June 30, 2013**
Public Record: **NO**

Reinstated Date:
Date of Expiration Prior to Reinstatement:

RECEIVED
OCT 02 2012
IDPR-MEDICAL UNIT

This license information was last updated on: 10/01/2012

If public record is indicated, submit a request for records to the following email address: mboard@msbml.state.ms.us.

Sincerely,

[redacted]

H. Vann Craig, M.D.
Executive Director

RECEIVED ELECTRONICALLY

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

STEVEN H. HILFINGER
DIRECTOR

VERIFICATION OF LICENSURE

MICHIGAN BOARD OF MEDICINE

VERIFICATION OF LICENSURE AS OF October 02, 2012

NAME: Willie James Parker **BIRTHDATE:** [redacted]

ADDRESS: [redacted]

TYPE: Medical Doctor **ORIGINAL DATE:** 05/08/2006

LICENSE NUMBER: 4301087686 **STATUS:** Lapsed **EXPIRATION DATE:** 01/31/2010

OBTAINED BY: Endorsement - Licensed >= 10 Years

EXAM DATE	EXAM TYPE	EXAM SCORE OR RESULT

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

This license information was last updated on: 9/29/2012

RECEIVED
OCT 0 2 2012
IDPR-MEDICAL UNIT

RECEIVED ELECTRONICALLY

RECEIVED
CASH SECTION
OCT 12 2012
IDFPR
Dept. of Professional Regulation

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

IMPORTANT NOTICE: Completion of this form is required by [illegible] et. seq. Illinois Compiled Statutes). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

FOR OFFICIAL USE ONLY

LIC#: 336-093257
PARKER, WILLIE JAMES
336 Cred #3266540 10/16/2012
By:NON-EXAM
SS[redacted]

Disclosure of your U.S. social security number, if you have one, is ***mandatory***, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

1. PROFESSIONAL NAME	2. PROFESSIONAL CODE - Check applicable box		3. LICENSURE METHOD	4. FEE
Physician Controlled Substances	☐ 319 Dentist	☑ 336 Physician	Registration	$5
	☐ 316 Podiatrist	☐ 390 Veterinarian		

PART II: Applicant Identifying Information

1. NAME LAST	FIRST	MIDDLE	2. TITLE (e.g., M.D., O.D., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
PARKER	WILLIE	J	MD	[redacted]

4. PERMANENT MAILING ADDRESS	CITY	STATE/COUNTRY	ZIP CODE	COUNTY
[redacted]				

5. NAME OF BUSINESS AND LOCATION (STREET / CITY / STATE / ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED
Family Planning Associates 5086 N Elston Avenue Chicago IL 60630

6. If you will ***not*** be storing or dispensing controlled substances, check the box below. Your license will be issued to your permanent mailing address.

☐ I will ***not*** be storing or dispensing controlled substances, including samples.

7. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)
Parker

8. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY
Work [redacted] FAX ( ) _____
Area Code
Home [redacted] FAX [redacted]
Work
Area Code Area Code

PART III: Drug Schedule

Circle the schedules for which you are applying:

(II) (IIN) (III) (IIIN) (IV) (V)

PART IV: Professional Activity

Practitioner–Check and complete one of the following:
pending
Professional License Number

☐ Dentist	019 -	_____
☑ Physician	036 -	131869
☐ Podiatrist	016 -	_____
☐ Veterinarian	090 -	_____

PART V: Personal History Information *(This part must be completed by all Applicants)*	YES	NO
1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)? *If yes, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		X
2. Have you been convicted of a felony?		X
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? If yes, attach a copy of the certificate. N/A		
4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.		X
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? If yes, attach a detailed explanation.		X
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? If yes, attach a detailed explanation.		X

PART VI: Child Support and/or Student Loan Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? Yes ☐ No ☒
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes ☐ No ☒

PART VII: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

October 1, 2017
Date of Application

[redacted]
Signature of Applicant

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

Application must be completed in its entirety.
If not completed, it will be returned to the address noted on front of application.

NAME (Last, First, MI): Parker, Willie J
SS#: [redacted]
Profession: Medicine