MD PROFILE PAGE

Arizona Medical Board

azmd.gov
Printed on 01/13/12 @ 04:27

General Information

William Richardson MD	License Number: 18829
Tucson Women's Center	License Status: Active
5240 E Knight Dr Ste 112	Licensed Date: 06/09/1989
Tucson AZ 85712-2122	License Renewed: 03/03/2010
Phone: (520) 323-9682	Due to Renew By: 03/30/2012
	If not Renewed, License Expires: 07/30/2012

Education and Training

Information up to the date of initial licensure is verified by the Board. Information provided by the physician after this date is not verified by the Board.

Medical School:	UNIV OF MI MED SCH Ann Arbor, Michigan
Graduation Date:	06/28/1985
Residency:	07/01/1985 - 06/30/1989 (Obstetrics & Gynecology) HENRY FORD HEALTH SYSTEM DETROIT , MI
Area of Interest	Obstetrics & Gynecology (ABMS Board Certified)

The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at http://www.abms.org to determine if the physician has earned a specialty certification from this private agency.

Board Actions

None

A person may obtain additional public records related to any licensee, including dismissed complaints and non-disciplinary actions and orders, by making a written request to the Board. The Arizona Medical Board presents this information as a service to the public. The Board relies upon information provided by licensees to be true and correct, as required by statute. It is an act of unprofessional conduct for a licensee to provide erroneous information to the Board. The Board makes no warranty or guarantee concerning the accuracy or reliability of the content of this website or the content of any other website to which it may link. Assessing accuracy and reliability of the information obtained from this website is solely the responsibility of the user. The Board is not liable for errors or for any damages resulting from the use of the information contained herein.

Please note that some Board Actions may not appear until a few weeks after they are taken, due to appeals, effective dates and other administrative processes.

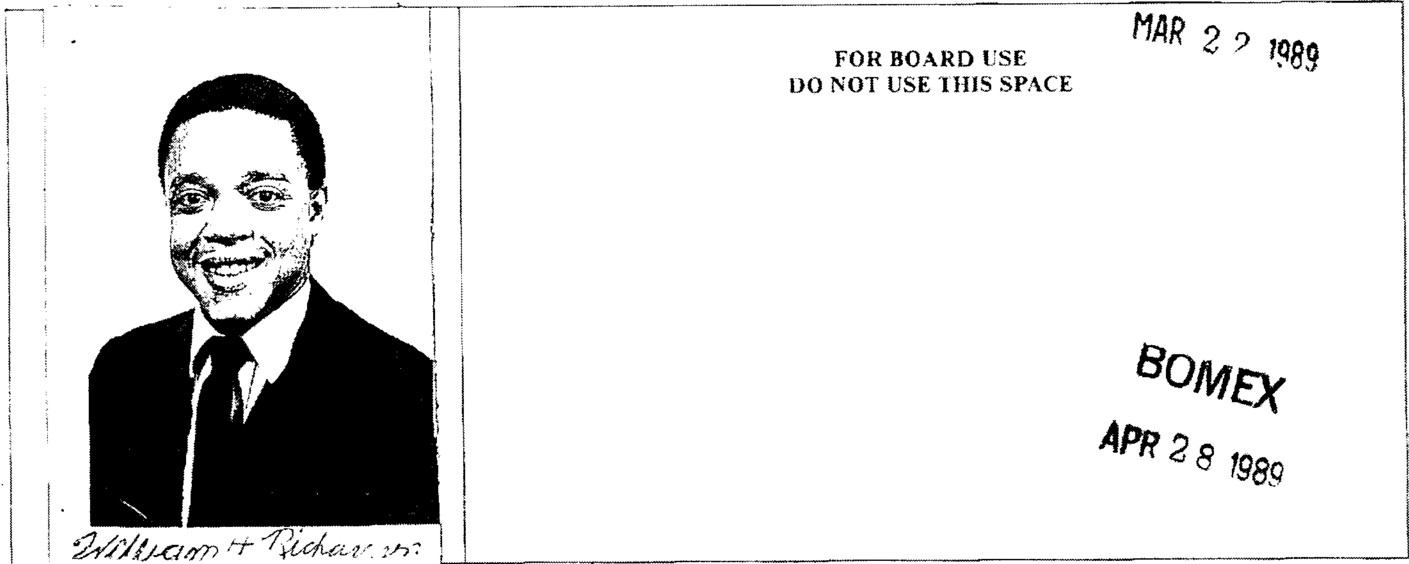
Board actions taken against physicians in the past 24 months are also available in a chronological list.

Credentials Verification professionals, please click here for information on use of this website.

ARIZONA BOARD OF MEDICAL EXAMINERS

2001 West Camelback Road, Suite 300
Phoenix, Arizona 85015
A C (602) 255-3751

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE THROUGH ENDORSEMENT



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

INFORMATION

All candidates shall provide satisfactory evidence that

1 He possesses 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.

NOTE: Applications are processed on a first-come first-served basis; the processing of a routine application can take 14 to 18 weeks.

Applications not fully complete within one year from date of receipt, including participation in an oral examination, if applicable, 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) a photocopy of birth certificate; or (b) an original Certificate of Naturalization, or (c) other documentary evidence for consideration (Visa, green 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 the following
(a) The secretary of the county medical society where you practiced for the three years prior to filing this application, and
(b) 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 $450 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 fifteen years preceding the filing of this application, are required to submit to oral examination in their specialty field of practice

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 8½ 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 nor 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 RICHARDSON (Last) WILLIAM (First) HENRY (Middle) (Maiden)

(a) Other names used. ______ Social Security No [redacted]

2 Address, Residence [redacted] (No) (Street) (City) (State) (Zip Code) (Phone)

Office 2799 WEST GRAND BLVD (No) (Street) DETROIT (City) MI (State) 48202 (Zip Code) 8762475 (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) MICHIGAN (Specify State Board) 11/88 (Date of Application) APPROVED (Result) 406168 (Certificate No)

~~2/89~~ 2/89 (Date Issued) CREDENTIALS (Specify if by Written Examination or on Credentials)

(b) ______ (Specify State Board) (Date of Application) (Result) (Certificate No)

______ (Date Issued) (Specify if by Written Examination or on Credentials)

5 Have you ever had an application for a license to practice medicine denied or rejected by another state/province licensing Board? NO (Answer)

6. Have any actions, restrictions, or limitations ever been imposed on you while participating in any type of training program? NO (Answer)

7. Have you ever been charged with a violation of any statute, rule or regulation of any domestic or foreign governmental agency? 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 cancelled during an investigation or in lieu of disciplinary action, or 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 involved in any malpractice matter which resulted in a settlement or judgement against you in excess of $20,000? NO (Answer)

12 Have you ever been convicted of Medicare or Medicaid fraud, received sanctions, including restriction, suspension or removal from practice imposed by an 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)

14 Have you ever been treated for the use of or misuse of any chemical substance or substances? [redacted] (Answer)

15 Have you ever been a patient in a mental or other institution of confinement, or have you ever been treated or received medication for a mental condition? [redacted] (Answer)

16. Are you suffering from any ailment communicable to others? [redacted] (Answer)

Note In the event the response to any of the questions numbered 5 through 16 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.

17 Are you presently in good physical and mental health? [redacted] (Answer)

(If NO, applicant shall file with this application, a detailed statement of his health, diagnosis and prognosis, supported by report of his attending physician)

18 Enter your height here 5' 11" weight 175# color of eyes GREEN color of hair BROWN

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

INTERNSHIP AND RESIDENCY IN OB/GYN AT HENRY FORD HOSPITAL IN DETROIT, MICHIGAN, 48202. LOCATED ON 2799 WEST GRAND BOULEVARD. FROM 1985 TO 1989

20. Are you American Board certified? NO Specialty

21. Have you completed the educational requirements for any of the American medical specialty boards? If so, which? OB/GYN

22 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 HENRY FORD, DETROIT (City) MI (State) from 7/1/85 to 6/30/89

At ______ (City) ______ (State) from ______ to ______

At ______ (City) ______ (State) from ______ to ______

At ______ (City) ______ (State) from ______ to ______

At ______ (City) ______ (State) from ______ to ______

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

YES Where? TUCSON ARIZONA

Solo or in Association with? IN ASSOCIATION WITH AN HMO

24. What is your intended specialty practice? OB/GYN

25. What branch of the United States Armed Forces have you served with, if any, including USPHS? ______

Active duty? From ______ (Month and Year) to ______ (Month and Year)

STATE OF MICHIGAN
County of WAYNE } ss

The applicant WILLIAM HENRY RICHARDSON, M.D.
(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 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 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 H Richardson, M.D.

(NOTARIAL SEAL)

Subscribed and sworn to before me this NINTH day of APRIL 19 89

Notary Signature Valeria Richardson (Notary Public) My Commission expires 8-7-90

BOMEX **FOR OFFICE USE ONLY**

APR 28 1989

Application Rec'd	19	Application Processed by	ct
Application Completed 5/22	19 89	Application Checked by	P.H.
Form No I Rec'd 5/1	19 89	Application Approved May 24	19 89
Form No II Rec'd 4/7	19 89	By	Carol Enninger, Mgr.
Form No. III Rec'd 3/31	19 89	License Issued 6-9	19 89
Form No. III Rec'd N/A	19	License No.	18829
Form No III Rec'd N/A	19		
Form No IV. Rec'd N/A	19		
Investigation Completed	19		

Application withdrawn ______ (Date)

Refund must be claimed by ______ (Date)

Warrants issued ______ (Numbers and Dates)

Warrants mailed ______ (Date)

Warrants cashed ______ (Date)

AS REQUESTED:

Ms. Kathleen Maslanka
Associate Executive Director
Wayne County Medical Society
1010 Antietam Road
Detroit, Michigan 48207
(313) 567-1640

photo on back

FORM I

RECEIVED

APR 2 . 1989

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, 2001 WEST CAMELBACK ROAD, SUITE 300, PHOENIX, ARIZONA 85015. Your early response will be appreciated.

Name WILLIAM H. RICHARDSON, M.D (Please Print or Type) — William H Richardson, M.D. (Signature)

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

Date 3/28/89

(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 HENRY RICHARDSON (Full Name of Student)

whose photograph is attached hereto, was granted the degree of DOCTOR OF MEDICINE by

The University of Michigan Medical School (Full Name of School or College of Medicine as it appears on the Applicant's Medical degree diploma) on June 28, 19 85,

that the date of his/her matriculation in medical school was September 4, , 19 80 ; and that he/she attended 4 yrs. of (Number) full courses of medical lectures comprising 8½ (Number) months each as verified by the attached certified copy of his/her transcripts

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 written explanation

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

4 Was applicant ever known to use or misuse any chemical substance or substances which required treatment or counseling? [redacted] If YES, please attach written explanation

5 Was applicant ever known to suffer from any mental health disorders which required treatment, counseling or medications? [redacted] If YES, please attach written explanation.

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

Signed [signature], M.D.

Carol A. Kauffman, M.D. - Assistant Dean for Student Affairs

Dean / President / Secretary / Registrar of The University of Michigan Medical School

(SEAL OF COLLEGE)

BOMEX MAY 01 1989

Date April 25, 19 89

Address 1301 Catherine Road - Ann Arbor, Michigan 48109-0611

Please return completed form DIRECT to:

Arizona Board of Medical Examiners, 2001 W. Camelback Rd., Suite 300, Phoenix, Arizona 85015

Revised 7/88

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.

Richardson, William

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, 2001 WEST CAMELBACK ROAD, SUITE 300, PHOENIX, ARIZONA 85015. Your early response will be appreciated.

Name: WILLIAM H. RICHARDSON, M.D. (Please Print or Type) — William H Richardson, M.D. (Signature)

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

Date: 3/28/89

(DO NOT DETACH)

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

This is to certify that WILLIAM HENRY RICHARDSON (Name of Applicant in Full), M.D., undertook and satisfactorily completed a full term approved program of 48 (Number) months in the HENRY FORD HOSPITAL 2799 W. GRAND BLVD DETROIT MICHIGAN 48202 (Full Name and Complete Address of Hospital) in the field of OBSTETRICS AND GYNELOLOGY from 7/1/85 (Date) to 6/30/89 (Date)

and that said program was approved for post graduate training during that period by the Council on Medical Education and Hospitals of the American Medical Association, or the Canadian Medical Association. 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 written explanation.
3. Was there any reason not to continue applicant in the training program? NO If YES, please attach written explanation.
4. Was applicant ever known to use or misuse any chemical substance or substances which required treatment or counselling? [redacted] If YES, please attach written explanation.
5. Was applicant ever known to suffer from any mental health disorders which required treatment or counselling? [redacted] If YES, please attach written explanation.
6. Were applicant's 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 Chairman - Obstetrics/Gynecology

Address 2799 W. GRAND BLVD

None (SEAL OF HOSPITAL) (So indicate, if none)

Date 3/29/89, 19__

BOMEX MAR 31 1989

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.

Richardson, William

NATIONAL BOARD OF MEDICAL EXAMINERS® • 3930 CHESTNUT STREET, PHILADELPHIA, PA 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

William H. Richardson, 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 C. WILLIAM DAESCHNER, JR., M.D.
Chairman of the Board

SEAL EDITHE J. LEVIT, M.D.
President of the Board

Philadelphia, Pa
07/01/86

Certificate # 318121

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from U MICHIGAN MEDICAL SCHOOL in JUNE 1985 and whose birth date is [redacted] This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners The scores obtained by this physician upon which his/her certification is based are as follows

	Standard Score	Scale Score
PART I passed 09/83		
Anatomy	420	75
Physiology	530	82
Biochemistry	525	82
Pathology	425	76
Microbiology	465	78
Pharmacology	535	83
Behavioral Sciences	570	85
TOTAL TEST (Minimum Passing Score 380/75	495	80
PART II passed 09/84		
Internal Medicine	430	79
Surgery	345	75
Obstetrics and Gynecology	550	85
Public Health and Preventive Medicine	410	78
Pediatrics	400	77
Psychiatry	545	84
TOTAL TEST (Minimum Passing Score 290/75	430	79
PART III passed 03/86		
A General Test of Clinical Competence		
TOTAL TEST (Minimum Passing Score 290/75	440	79.9
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		79.0

*For those individuals who have not yet satisfactorily completed one full year of post-M D training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded

Melanie Valente
Secretary for Certification

SEAL

04/05/89
Date

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

SATISFACTION OF REQUIREMENTS SUMMARY

ENDORSEMENT

APPLICATION Received April 28, 1989

NAME IN FULL ✓ RICHARDSON (Last) WILLIAM (First) HENRY (Middle)

Current Address ✓ [redacted]

Telephone ✓ [redacted] (Residence) (313) 876-2475 (Office)

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

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

MEDICAL EDUCATION ✓ University of Michigan Medical School Ann Arbor, MI 025-01 (Full Name and Location of Medical School)

✓ M.D. Awarded: June 28, 1985 Proof Received: 5/1/89 ☑ Approved

ECFMG Certificate No. Dated: Proof Received:

POSTGRADUATE TRAINING

Form III ✓ In OBG (Field of Training) for 47 months at Henry Ford Hospital Detroit, MI (Name of Institution)

✓ From July 1, 1985 to Date'89(will comp 6/30/89)

In (Field of Training) for months at (Name of Institution)

From to

In (Field of Training) for months at (Name of Institution)

From to

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 NONE (Specialty) Certificate No. Issued

Of (Specialty) Certificate No. Issued

PRACTICE ✓ Field of OBG (Current)

LICENSES

Form II ✓ Endorsement through National Board ; No. 318121 (Certificate) ; Issued 7/1/86 (Date) W/E

✓ Michigan#406168, 12/19/88 ;[ ] W/E [X] Reciprocity With National Board

In ;[ ] W/E [ ] Reciprocity With

In ;[ ] W/E [ ] Reciprocity With

In ;[ ] W/E [ ] Reciprocity With

In ;[ ] W/E [ ] Reciprocity With

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In ;[ ] W/E [ ] Reciprocity With

(TUMBLE)

U.S. MILITARY OR PUBLIC HEALTH SERVICE	Served in NONE (Branch) From to Honorable Discharge Received Discharge Rank
PREVIOUS PRACTICE	In Detroit(internship/residency)MI From July 1 1985 to Date 1989 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 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 # Endorsement $ 450.00 Receipt # A 029552
INVESTIGATION	AMA Approval 4/10/89, record clear, N/D Michigan Board Approval 5/22/89, Cert.#406168, iss. 12/19/88, End., current, N/D Fed State Board Approval 4/10/89, reocrd clear, N/D Board Approval Board Approval Board Approval Board Approval Board Approval Board Approval Board Approval Board Approval Ass'n Approval Ass'n Approval Ass'n Approval
INTENDED LOCATION	Tucson

ct

5/1/89

5/1/89 ok 5/24/89 ee

Governor
Fife Symington
Chairman
Nicholas J Soldo, M D
Vice Chairman
Barry A Friedman, M D
Secretary
Burton N Drucker

THE ARIZONA BOARD OF MEDICAL EXAMINERS

2001 West Camelback Road, Suite 300 • Phoenix, Arizona 85015
Telephone (602) 255-3751

Executive Director
Douglas N Cerf
Assistant Director for Licensure and Administration
Mark R Speicher

CERTIFIED MAIL /RETURN RECEIPT REQUESTED

March 30, 1993

William Richardson, M.D.

RE: Pima County Health Department (Patient: B.A.D.) vs. William Richardson, M.D. (Complaint) (Inv. #1143)

Dear Doctor Richardson:

During the course of its meeting of **January 20, 1993**, the Board of Medical Examiners considered the above-referenced matter.

Following a complete and detailed review of all pertinent and available information, the Board concluded in Open Session that this matter should be filed with an advisory Letter of Concern.

Specifically, the Board was concerned that you failed to sign a birth certificate in an appropriate timely manner.

Please be advised that the Board will retain this file for future reference should similar problems arise. The Board determined to take no other formal action at this time.

On behalf of the Board of Medical Examiners, please accept my appreciation for your assistance and cooperation in this matter.

Sincerely,

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

DOUGLAS N. CERF
Executive Director

DNC/kjm
CLC#11

cc: Pima County Health Department

BOMEX Inquiry (09/15/92) vs. Ray P. Inscore, M.D. (GP-FP - Prescott) (C) (Inv. #3720) CLC#9

Following a review of all pertinent records and discussion of the complaint matter, it was moved by Doctor Zonis, seconded by Doctor Friedman, and unanimously carried that this matter be filed with an advisory *Letter of Concern* to Doctor Inscore for excessive prescribing of the schedule IV drug Halcion and inadequate documentation in his office records for the continued use of schedule III drugs for patients J.S. and C.S.

K.L. vs. Ingrid Haas, M.D. (OBG-Scottsdale) (C) (Inv. #1) CLC#10
(Doctor Zonis did not participate or vote in this matter.)

Following a review of all pertinent records and discussion of the complaint matter, it was moved by Doctor Holsey, seconded by Doctor DeBenedetti, and unanimously carried that this matter be filed with an advisory *Letter of Concern* to Doctor Haas for leaving the patient unattended in light of the fact she was receiving pitocin and delivery was imminent as well as the patient's blood pressure and fetal heart tracings raised cause for concern.

Pima County Health Department (Patient: B.A.D.) vs. William Richardson, M.D. (OBG-Tucson) (C) (Inv. #1143) CLC#11

Following a review of all pertinent records and discussion of the complaint matter, it was moved by Doctor Friedman, seconded by Doctor Voss, and unanimously carried that this matter be filed with an advisory *Letter of Concern* to Doctor Richardson for failure to sign a birth certificate in an appropriate timely manner.

Informal Interview

R.L.C. (Patient: A.C. (10/10/90) vs. David Ruben, M.D. (C) (Inv. #2350) - Informal Interview

Doctor Ruben was requested to appear at this date and time; did appear and was interviewed by members of the Board relative to allegations of inappropriate care.

Following the Board's review and discussion of this matter, it was moved by Doctor Zonis, seconded by Doctor Shack, and unanimously carried that this matter be *dismissed* against Doctor Ruben.

THOMAS-DAVIS
Medical Centers, P.C.

Since 1920

November 8, 1995

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

To Whom It May Concern:

Please be advised that on November 20, 1995, Dr. William Richardson (AZ License #18829) will join Thomas-Davis Medical Centers, P.C.

His office address will be:

Thomas-Davis Medical Center
707 N. Alvernon Way
Tucson, AZ 85711

Phone: (520) 881-7100

If you have any questions, please call me at (520) 322-2624.

Sincerely,

Donna M. Bergman
Medical Staff Coordinator

655 N Alvernon, Suite 218
P.O Box 12650
Tucson, AZ 85732
(602) 322-2513
Fax (602) 322-2574

mood 11/14/95

RECEIVED B.O.M.E.X.
NOV 13 95

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

2001 West Camelback Road, Suite 300, Phoenix, Arizona 85015

CERTIFIED MAIL-RETURN RECEIPT REQUESTED

Date: June 9, 1989

Re: License through Endorsement

William Henry Richardson, M.D.

Dear Doctor:

Congratulations! Your certificate to practice medicine in Arizona, License No. 18829 issued on JUNE 9, 1989 is enclosed with your pocket registration card for the current year.

Please be advised that annual reregistration is mandatory on a calendar-year basis, with notices generally being mailed to your address of record on or about November 1 of each year. Failure to reregister will result in statutory expiration of your license. It is your responsibility to keep us informed of address changes. Please note that 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."

It is also 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. Failure to do so is actionable against your license to practice. (A.R.S. §32-1451(A).

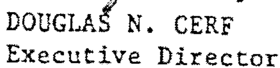
You will receive a copy of the Arizona State Medical Directory published yearly by the Board which contains the Arizona Medical Practice Act. We suggest that you familiarize yourself with such prior to establishing your practice in Arizona.

Enclosed for your information is that part of the Arizona Medical Practice Act which relates to Unprofessional Conduct, together with Continuing Medical Education information for annual reregistration and Prescription Form requirements.

Please feel free to contact this office at any time should you have any questions.

Cordially,

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA



DOUGLAS N. CERF
Executive Director

DNC/ce
Enclosures: 6

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

2001 West Camelback, Suite 300, Phoenix, Arizona 85015, (602) 255-3751

DATE: May 26, 1989

William Henry Richardson, M.D.

Re: License through Endorsement

Dear Doctor:

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 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 Arizona Board of Medical Examiners, 2001 West Camelback Road, Suite 300, Phoenix, Arizona 85015. The card must be in hand by Thursday of each week in order for your license to be issued the following day. DO NOT COMMENCE PRACTICE IN ARIZONA UNTIL A LICENSE NUMBER HAS BEEN ASSIGNED.

The Board publishes an annual directory of all its licentiates, which is distributed about 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. The cut-off date for address changes for the directory is July 31 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).

Thank you for your cooperation.

Cordially,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

Licensing Department
Encs. 3

Richardson, William

STATE OF MICHIGAN

JAMES J BLANCHARD, Governor

DEPARTMENT OF LICENSING AND REGULATION

RAYMOND W HOOD, SR, Director
P O Box 30018
Lansing, Michigan 48909
Telephone (517) 373-1870

May 16, 1989

Board of Medical Examiners
State of Arizona
2001 West Camelback Road, Suite 300
Phoenix, AZ 85015

TO WHOM IT MAY CONCERN:

I hereby certify that a standard search of the available records of the Michigan Department of Licensing and Regulation, Bureau of Health Services indicates the following:

WILLIAM H. RICHARDSON, M.D.

WAS ISSUED LICENSE NO.	406168
ON:	December 19, 1988
TO PRACTICE AS A:	Medical Doctor
DATE OF BIRTH:	[redacted]
LICENSURE STATUS IS:	Active until 1-31-90
ISSUED ON THE BASIS OF:	National Boards
REGULATORY INFORMATION:	None

The above format is the standard format prepared for all the professions regulated by this Bureau. If other information is needed, please contact this office at (517) 373-7902.

Sincerely,

Susan Henderson

(SEAL)

Susan Henderson, Clerk
MICHIGAN BOARD OF MEDICINE

SOMEX

MAR 22 1989

MAY 22 1989

PRINTED ON RECYCLED PAPER

Executive Director
Douglas N Cerf

Assoc Executive Director
David O Landrith

Manager, Licensure Dept
Carol Emminger

Telephone
(602) 255-3751

THE ARIZONA BOARD OF MEDICAL EXAMINERS

2001 west camelback road, suite 300 • phoenix, arizona 85015

May 1, 1989

William Henry Richardson, M.D.

Re: License through Endorsement

Dear Doctor:

This will acknowledge receipt of your application for a license to practice medicine in Arizona through endorsement. Our receipt number A 029552 covering your fee deposit of $450.00 is enclosed, with a schedule of examination dates and filing deadlines, if applicable.

To complete our processing of your application, we need to receive the following:

Form I Medical College Certification. received 5-1-89

Verification of License from Michigan, 5/22 enclosed find correspondence from Michigan that was inadvertently sent to this office.

Continued:

NOTE: FINAL ACTION ON YOUR APPLICATION CANNOT BE TAKEN UNTIL ALL THESE RESPONSES ARE IN YOUR FILE OF RECORD, WHICH IS YOUR RESPONSIBILITY.

PLEASE BE ADVISED THAT APPLICATIONS NOT FULLY COMPLETED WITHIN ONE YEAR FROM THIS DATE, INCLUDING PARTICIPATION IN WRITTEN EXAMINATIONS, IF APPLICABLE, ARE CONSIDERED WITHDRAWN.

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

Cordially,

BOARD OF MEDICAL EXAMINERS
STATE OF ARIZONA

(Mrs.) Carol Emminger
Manager, Licensure Department

CE: ct

Encs. 4

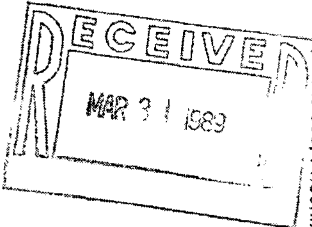
Richardson, William

BOARD OF MEDICAL EXAMINERS OF THE STATE OF ARIZONA

2001 West Camelback, Suite 300, Phoenix, Arizona 85015, (602) 255-3751

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

Date: 3/28/89



Coordinator, Disciplinary Data Bank
Federation of State Medical Boards
2630 West Freeway, Suite 138
Fort Worth, Texas 76102-7999

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

Name: RICHARDSON (Last) WILLIAM (First) HENRY (Middle)

[redacted]
Address

[redacted]
City, State and Zip

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

[redacted]
Date of Birth

[redacted]
Social Secruity Number

BRYANT L. GALUSHA, M.D.
EXECUTIVE VICE-PRESIDENT

UNIVERSITY OF MICHIGAN ANN ARBOR (MI)
Medical School of Graduation and Branch Location

6/30/85
Date of Graduation

Please mail the response to the following:

Arizona Board of Medical Examiners
2001 West Camelback Road, Suite 300
Phoenix, Arizona 85015

William H Richardson MD
Signature

BOMEX
APR 10 1989

FEB 16 1989

Richardson, William
(FOR OFFICE USE ONLY)

PRELIMINARY QUESTIONNAIRE

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 eligibilty 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, 2001 West Camelback Road, Suite 300, Phoenix, Arizona 85015. PLEASE *PRINT* ALL INFORMATION.

Full Legal Name: WILLIAM (FIRST) HENRY (MIDDLE) RICHARDSON (LAST)

Current Office Address: 2799 WEST GRAND BLVD

City: DETROIT State: MI Zip Code: 48202 Area Code: 313 Phone: 8762600

Current Residence Address: [redacted]

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

MEDICAL SCHOOL: Name UNIVERSITY OF MICHIGAN ok 025-01

City and State: ANN ARBOR MICHIGAN Date of Degree: 1985

If transferred from other medical school, please indicate name:

Name of any medical school attended but did not graduate or transfer from:

5TH PATHWAY PROGRAM: U.S. Medical School:

HOSPITAL: City: State:

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

INTERNSHIP: (List U.S. & Canadian only) HOSPITAL HENRY FORD HOSPITAL

City DETROIT State: MICHIGAN ok.

Term: Started: JULY 1, 1985 (MONTH AND YEAR) Completed JUNE 30, 1986 (MONTH AND YEAR) 4yr ok.

RESIDENCY: (List U.S & Canadian only) HOSPITAL: HENRY FORD HOSPITAL

City DETROIT State: MICHIGAN

Term. Started: JULY 1986 (MONTH AND YEAR) Completed JUNE 30 1989 (MONTH AND YEAR)

Specialty Field: GYNECOLOGY AND OBSTETRICS

RESIDENCY: (List U.S. & Canadian only) HOSPITAL:

City: State:

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

Specialty Field:

(NOTE Attach separate list for additional Residency and/or Fellowship)

(FOR OFFICE USE ONLY)

INFORMATION FORM FORWARDED 19

Col. Exam

RECIPROCITY - EXAMINATION FORWARDED 3-22 1989

BOMEX MAR 16 1989

APPLICATION & FORMS I II III IV V VI VII NB-1

Ama Fed St. 1Lic.

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

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

State Board Exam? NO Name of State ________ Cert. No. ________ Date Issued. ________

National Board Exam? YES Cert. No. 318121 Date Issued : 7/1/86

LMCC (Canada)? ________ Cert. No ________ Date Issued : ________

FLEX Exam *prior to January 1, 1985?* NO Did you receive a minimum grade of seventy percent (70%) on each **DAY** of the Examination? Yes ______ No ______ .

If "Yes", were Flex grades obtained in one sitting? Yes ______ No ______ .

FLEX Exam *after January 1, 1985?* ______ Did your receive a minimum grade of seventy-five percent (75%) in each, Component I and Component II? Yes ______ No ______ .

Date Component I was taken ________ (MONTH & YEAR) Date Component II was taken : ________ (MONTH & YEAR)

SPECIAL PURPOSE EXAMINATION (SPEX) : ________ Date SPEX examination was taken : ________ (MONTH & YEAR)

Did you receive a minimum grade of seventy-five percent (75%)? ________

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

If "Yes," which Board(s)? ________

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

Yes ✓ No ______ If "Yes," which Board(s)? OBSTETRICS /GYNECOLOGY

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

(1) MICHIGAN (2) ______ (3) ______ (4) ______ (5) ______

(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. : ________

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

PRACTICE : City & State Where You Now Practice · DETROIT MICHIGAN

Date Above Practice Was Established POST GRADUATE TRAINING

CITIZENSHIP :

(✓) Birth

( ) Naturalization

( ) Declaration of Intention

( ) Hold Permanent Immigrant Status

( ) Awaiting Quota Assignment

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

MILITARY (United States Only):

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

Dates of Active Duty ____________ Type of Discharge: ____________

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

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

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 ✓

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 ✓

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 ____ No ✓

Have you ever had hospital privileges revoked, denied; suspended or restricted in any way? Yes ____ 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 H Ruhan, M.D. DATE: 3/11/89

SOCIAL SECURITY NO.: [redacted]

REGULAR LICENSURE. Regular licenses to practice medicine in the State of Arizona may be offered through Written Examination or Endorsement or Endorsement with SPEX Examination; the Applicant being qualified for the method of entrance by education, postgraduate education, experience or practice to the extent required by Arizona Revised Statutes.

WRITTEN EXAMINATION. Arizona offers the FLEX Examination to qualified candidates. (**NOTE:** Arizona accepts the results of the FLEX Examination taken in these United States for endorsement purposes; however, we cannot present the FLEX Examination for other jurisdictions, nor permit Arizona candidates to partake of the FLEX Examination elsewhere.)

An Applicant must obtain a grade of **seventy percent (70%)** or more on *each day* of the Examination and a **weighted average of seventy-five percent (75%)** or more on the complete FLEX Examination taken *prior* to January 1, 1985.

The successful passage of a FLEX Examination prior to January 1, 1985 must be achieved at one sitting.

An Applicant must obtain a score of **seventy-five percent (75%)** in each Component I and Component II on the FLEX Examination taken *after* January 1, 1985. The successful passage of both Components must be achieved within a three-year period

ENDORSEMENT and/or SPEX EXAMINATION. Endorsement is offered to otherwise eligible Applicants upon successful passage of a written examination administered by another State, Territory or District of the United States, the Medical Council of Canada, or the Applicant is certified by the National Board of Medical Examiners. An Applicant seeking licensure based upon another jurisdiction's examination, shall establish to the satisfaction of the Arizona Board of Medical Examiners that the examination is substantially equivalent to the examination required by the Arizona Board of Medical Examiners, and that the Applicant's score on the examination was equal to the score required by the State of Arizona for licensure by examination.

If said examination or certificate was more than **ten (10)** years preceding the application, the Applicant *must* submit to a SPEX Examination NOTE: Arizona accepts the results of the SPEX Examination taken in these United States for licensure pursuant to ARS §32-1426(C). SPEX score must be 75% or better.

FIFTH PATHWAY PROGRAM. If a Fifth Pathway Program was completed as part of postgraduate training, the Arizona Board of Medical Examiners requires completion of one academic year of supervised clinical training under the direction of an approved school of medicine in the United States.

NOTE: The above FLEX/SPEX grade requirements are set statutorily and cannot be waived by the Board. Certification of scores must be sent directly to this office from the Federation of State Medical Boards of the United States, 2630 West Freeway, Suite 138, Fort Worth, TX 76102. The Federation charges $35.00 for this service; vouchers must be a Cashier's Check. To expedite the review of your qualifications to receive an application, you may wish to contact the Federation to send grades/test results to this Board at the time you complete this questionnaire.

Revised 1/89

Janet Napolitano
Governor

Timothy C. Miller, J.D.
Executive Director

Amanda J. Diehl, M.P.A., C.P.M.
Deputy Executive Director

Bernadette E. Phelan, Ph.D.
Assistant Director

Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258-5514
Telephone: 480-551-2700 • Toll Free: 877-255-2212 • Fax: 480-551-2704
Website: www.azmd.gov • Email: questions@azmd.gov

Tim B. Hunter, M.D.
Chair

William R. Martin, III, M.D.
Vice-Chair

Douglas D. Lee, M.D.
Secretary

September 21, 2005

PERSONAL and CONFIDENTIAL

William H. Richardson, M.D.
5240 E. Knight Drive
Suite 112
Tucson, Arizona 85712

**Re: T.B. vs. William H. Richardson, M.D.
Investigation No. MD-05-0139A**

Dear Dr. Richardson:

The Arizona Medical Board has thoroughly investigated this case and found no violation of the Medical Practice Act. Therefore, this case has been dismissed.

The complainant may appeal this dismissal within 35 days of the date of this letter. If this should occur, you will be notified by mail.

Sincerely,

Timothy C. Miller, J.D.
Executive Director

TCM/cl

Enclosures

Cc: Investigative File

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
Home Page: http://www.azmdboard.org

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: William Henry Richardson, MD

LICENSE #: 18829

SPECIALTY: ______________________

PAID CC 6/7/04

CHECK ONE: ☐ Initial Registration ($200) ☑ Renewal Registration ($100)

- Please list below ALL locations where you will be dispensing prescription drugs, devices and controlled substances.
- For each location, place a check mark next to the descriptions of the prescription items which will be dispensed from that location.
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.

PLEASE NOTE
A *separate* DEA license must be submitted for *EACH* location where controlled substances will be dispensed and must be kept current during the registration period.

PRIMARY PRACTICE LOCATION: DEA # FOR THIS LOCATION:

Street Address		City/State/Zip Code	
5240 E Knight Dr. #112		Tucson Az 85712	
Phone Number		Fax Number	E Mail
520-323-9682		520-323-9689	[redacted]

Schedule II Drugs	✓	Schedule III Drugs	✓	Prescription-Only Drugs	✓	Nubain	✓
Schedule IV Drugs	✓	Schedule V Drugs	✓	Prescription Devices	✓		

ADDITIONAL PRACTICE LOCATION: DEA # FOR THIS LOCATION:

Street Address		City/State/Zip Code	
Phone Number		Fax Number	E Mail

Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

List any additional locations on the reverse side of this form and place a check mark here ☐

Physician's Signature: [signature] Date: 6-7-04

Initial registration fee: $200.00 *per physician* Renewal registration fee: $100.00 *per physician*

Make checks or money orders payable to ARIZONA MEDICAL BOARD
For your convenience, we accept payments by Visa or MasterCard
If you wish to pay by payment card, please complete the attached
PAYMENT CARD AUTHORIZATION FORM

ADDITIONAL PRACTICE LOCATION: DEA # FOR THIS LOCATION:

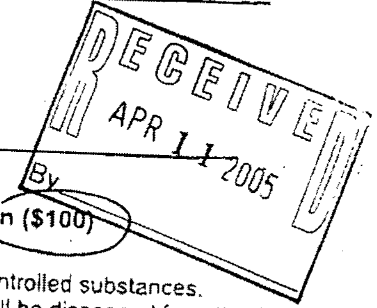
ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
Home Page: http://www.azmdboard.org

Pd
cc

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **



PHYSICIAN NAME: William Richardson, MD

LICENSE #: 18829

SPECIALTY: OBGYN

CHECK ONE: ☐ Initial Registration ($200) ☒ Renewal Registration ($100)

- Please list below ALL locations where you will be dispensing prescription drugs, devices and controlled substances.
- For each location, place a check mark next to the descriptions of the prescription items which will be dispensed from that location.
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.

PLEASE NOTE
A separate DEA license must be submitted for *EACH* location where controlled substances will be dispensed and must be kept current during the registration period

PRIMARY PRACTICE LOCATION: DEA # FOR THIS LOCATION: [redacted] 4/30/07

Street Address				City/State/Zip Code			
5240 E. KNIGHT #112				TUCSON, AZ 85712			
Phone Number				Fax Number		E Mail	
(520) 323-9687				(520) 323-9689			
Schedule II Drugs	X	Schedule III Drugs	X	Prescription-Only Drugs	X	Nubain	X
Schedule IV Drugs	X	Schedule V Drugs	X	Prescription Devices	X		

ADDITIONAL PRACTICE LOCATION: DEA # FOR THIS LOCATION:

Street Address				City/State/Zip Code			
Phone Number				Fax Number		E Mail	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

***List any additional locations on the reverse side of this form and place a check mark here: ☐

Physician's Signature: [signature] Date: 4.11.05

Initial registration fee: $200.00 *per physician* Renewal registration fee: $100.00 *per physician*

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa or MasterCard

If you wish to pay by payment card, please complete the attached
PAYMENT CARD AUTHORIZATION FORM

PD CK 15822

23

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
Home Page: http://www.azmd.gov

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

RECEIVED BY:
MAY 18 2006
ARIZONA MEDICAL BOARD
BUSINESS OPERATIONS

PHYSICIAN NAME: William Richardson, MD

LICENSE #: **18829**

SPECIALTY: OB/GYN

CHECK ONE: ☐ Initial Registration ($200) ☒ Renewal Registration ($150)

- Please list below ALL locations where you will be dispensing prescription drugs, devices and controlled substances.
- For each location, place a check mark next to the descriptions of the prescription items which will be dispensed from that location.
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.

PLEASE NOTE
A *separate* DEA license must be submitted for *EACH* location where controlled substances will be dispensed and must be kept current during the registration period

PRIMARY PRACTICE LOCATION: | DEA # FOR THIS LOCATION: [redacted] 4/30/07

Street Address	City/State/Zip Code	
5240 E KNIGHT DR. #112	TUCSON, AZ 85712	
Phone Number	**Fax Number**	**E Mail**
(520) 323-9682	(520) 323-9631	[redacted]

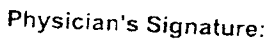
Schedule II Drugs	✓	Schedule III Drugs	✓	Prescription-Only Drugs	✓	Nubain	✓
Schedule IV Drugs	✓	Schedule V Drugs	✓	Prescription Devices	✓		

ADDITIONAL PRACTICE LOCATION: | DEA # FOR THIS LOCATION:

Street Address	City/State/Zip Code	
Phone Number	**Fax Number**	**E Mail**

Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

***** List any additional locations on the reverse side of this form and place a check mark here: ☐



Physician's Signature: [signature] Date: 5.16.06

Initial registration fee: $200.00 *per physician*   Renewal registration fee: $150.00 *per physician*

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa or MasterCard

If you wish to pay by payment card, please complete the attached PAYMENT CARD AUTHORIZATION FORM.

RECD Pd CC

JUN 1 1 2007

ARIZONA MEDICAL BOARD

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
Home Page: http://www.azmd.gov

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: William Richardson, MD

LICENSE #: 18829

SPECIALTY: OB/GYN

CHECK ONE: ☐ Initial Registration ($200) ☒ Renewal Registration ($150)

- Please list below ALL locations where you will be dispensing prescription drugs, devices and controlled substances.
- For each location, place a check mark next to the descriptions of the prescription items which will be dispensed from that location.
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.

PLEASE NOTE

A *separate* DEA license must be submitted for *EACH* location where controlled substances will be dispensed and must be kept current during the registration period

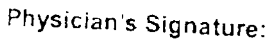
PRIMARY PRACTICE LOCATION: DEA # FOR THIS LOCATION: expired

Street Address				City/State/Zip Code			
5240 E Knight Drive #112				Tucson, AZ 85712			
Phone Number				Fax Number		E Mail	
520-323-9682				520-323-9689		[redacted]	
Schedule II Drugs	✓	Schedule III Drugs	✓	Prescription-Only Drugs	✓	Nubain	✓
Schedule IV Drugs	✓	Schedule V Drugs	✓	Prescription Devices	✓ -only		

ADDITIONAL PRACTICE LOCATION: DEA # FOR THIS LOCATION:

Street Address				City/State/Zip Code			
Phone Number				Fax Number		E Mail	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

***** List any additional locations on the reverse side of this form and place a check mark here: ☐



Physician's Signature: [signature] Date: 5-9-07

Initial registration fee: $200.00 *per physician* Renewal registration fee: $150.00 *per physician*

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa or MasterCard

If you wish to pay by payment card, please complete the attached PAYMENT CARD AUTHORIZATION FORM

ENTERED

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
Home Page: http://www.azmd.gov

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: WILLIAM RICHARDSON, MD

RECEIVED
MAY 23 2008
ARIZONA MEDICAL BOARD
BUSINESS OPERATIONS

LICENSE #: 13829

Renewal Registration FEE ($150) If received by June 30, 2008

PLEASE NOTE
A ***separate*** DEA license must be submitted for ***EACH*** location where controlled substances will be dispensed and must be kept current during the registration period

Place a check mark next to description below of all items which will be dispensed from all locations. (Certificate will be issued only for items that are checked)

Schedule II Drugs	✓	Schedule III Drugs	✓	Prescription-Only Drugs	✓	Nubain	
Schedule IV Drugs	✓	Schedule V Drugs	✓	Prescription Devices	✓		

Your certificate will be issued for Prescription-Only Drugs and Devices if a DEA registration is not submitted for *each location.*

PRIMARY PRACTICE LOCATION:

5240 E. KNIGHT #112 TUCSON, AZ 85712 (502)323-96

Street Address City, State, Zip Code Phone #

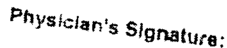
[redacted] 3/1/2007 4/30/2010 ✓

DEA # for this location (Attach Copy of DEA) Issued Date Expiration Date

ADDITIONAL PRACTICE LOCATION:

Street Address City, State, Zip Code Phone #

DEA # for this location (Attach Copy of DEA) Issued Date Expiration Date



Physician's Signature: [signature] Date: 5/19/2008

Renewal registration fee: $150.00 per physician

ENTERED 6/5 5/27/08

Make checks or money orders payable to ***ARIZONA MEDICAL BOARD***
For your convenience, we accept payments by Visa or MasterCard
If you wish to pay by payment card, please complete the attached
PAYMENT CARD AUTHORIZATION FORM

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
Home Page: http://www.azmd.gov

RECEIVED
MAY 11 2009
AZ MEDICAL BOARD

DISPENSING PHYSICIAN INITIAL REGISTRATION AND ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: William H. Richardson

LICENSE #: 18629 SPECIALTY: ob/gyn

CHECK ONE: ☐ Initial Registration ($200) ☒ Renewal Registration ($150)

- Please list below ALL locations where you will be dispensing prescription drugs, devices and controlled substances.
- For each location, place a check mark next to the descriptions of the prescription items which will be dispensed from that location.
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.

PLEASE NOTE

A *separate* DEA license must be submitted for *EACH* location where controlled substances will be dispensed and must be kept current during the registration period

PRIMARY PRACTICE LOCATION: **DEA # FOR THIS LOCATION:** 4/30/10

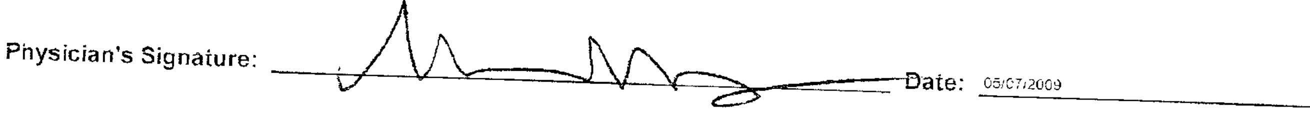
Street Address				City/State/Zip Code			
5240 E. Knight Drive Suite 112				Tucson, AZ 85712			
Phone Number				**Fax Number**		**E Mail**	
520-323-9682				520-323-9689		[redacted]	
Schedule II Drugs	✓	Schedule III Drugs	✓	Prescription-Only Drugs	✓	Nubain	
Schedule IV Drugs	✓	Schedule V Drugs	✓	Prescription Devices	✓		

ADDITIONAL PRACTICE LOCATION: **DEA # FOR THIS LOCATION:**

Street Address				City/State/Zip Code			
Phone Number				**Fax Number**		**E Mail**	
Schedule II Drugs		Schedule III Drugs		Prescription-Only Drugs		Nubain	
Schedule IV Drugs		Schedule V Drugs		Prescription Devices			

***** List any additional locations on the reverse side of this form and place a check mark here: ☐

Physician's Signature:



Date: 05/07/2009

Initial registration fee: $200.00 *per physician*

Renewal registration fee: $150.00 *per physician*

Make checks or money orders payable to ARIZONA MEDICAL BOARD

For your convenience, we accept payments by Visa or MasterCard

If you wish to pay by payment card, please complete the attached
PAYMENT CARD AUTHORIZATION FORM

ENTERED

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2761 . Fax (480) 551-2704
Home Page: http://www.azmd.gov

RECEIVED
MAY 17 2010
AZ MEDICAL BOARD

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

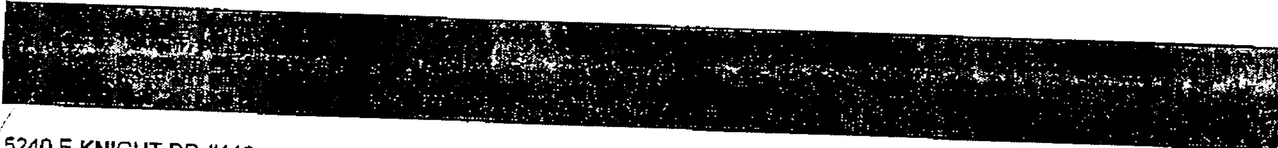
PHYSICIAN NAME: William Henry Richardson, MD

MD LICENSE #: 18829

SPECIALTY: OB/GYN

☒ **Renewal Registration ($150) (Renewal & fee must come together postmarked or faxed by 6/30)**

- Confirm ALL locations below where you will be dispensing prescription drugs, devices and controlled substances. (For each location, place a check mark to verify address and schedule of drugs dispensed from each location are correct)
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.
- Blank form attached to add additional locations



✓ 5240 E KNIGHT DR #112
TUCSON, AZ 85712

Schedule II Drugs
Schedule III Drugs
Schedule IV Drugs
Schedule V Drugs
Prescription Only Drugs
Prescription Devices

☒ Dispensing location information correct ☒ Copy of DEA attached ☐ Remove this location

Physician's Signature: [signature] Date: 5/11/2010

RICHARDSON, WILLIAM H MD
5240 E. KNIGHT DR.
SUITE 112
TUCSON, AZ 85712-0000-000

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	04-30-2013	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	03-04-2010

RICHARDSON, WILLIAM H MD
5240 E. KNIGHT DR.
SUITE 112
TUCSON, AZ 85712-0000

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	04-30-2013	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	03-04-2010

RICHARDSON, WILLIAM H MD
5240 E. KNIGHT DR.
SUITE 112
TUCSON, AZ 85712-0000

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

Form DEA-223 (4/07)

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

ARIZONA MEDICAL BOARD

9545 E. Doubletree Ranch Road . Scottsdale, Arizona 85258 Telephone: (480) 551-2700 . Fax (480) 551-2704
Website: www.azmd.gov

RECEIVED
JUN 23 2011
AZ MEDICAL BOARD

DISPENSING PHYSICIAN ANNUAL RENEWAL FORM

** Please Type or Print **

PHYSICIAN NAME: William Henry Richardson, MD

MD LICENSE #: 18829

SPECIALTY: OB/GYN

☑ Renewal Registration ($150) (Renewal & fee must come together postmarked or faxed by 6/30)

- Confirm ALL locations below where you will be dispensing prescription drugs, devices and controlled substances. (For each location, place a check mark to verify address and schedule of drugs dispensed from each location are correct)
- Include a copy of your DEA license if you are requesting dispensing of controlled substances at any location.
- Blank form attached to add additional locations

PLEASE NOTE

A **separate** DEA license must be submitted for ***EACH*** location where **controlled substances** will be dispensed and must be kept current during the registration period

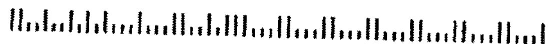
5240 E KNIGHT DR #112
TUCSON, AZ 85712

Schedule II Drugs
Schedule III Drugs
Schedule IV Drugs
Schedule V Drugs
Prescription Only Drugs
Prescription Devices

☑ Dispensing location information correct ☑ Copy of DEA attached ☐ Remove this location

Physician's Signature: [signature] Date: 6-7-2011

RICHARDSON, WILLIAM H MD
5240 E. KNIGHT DR.
SUITE 112
TUCSON, AZ 85712-0000-000



DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	04-30-2013	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	03-04-2010

RICHARDSON, WILLIAM H MD
5240 E. KNIGHT DR.
SUITE 112
TUCSON, AZ 85712-0000

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

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CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON D.C. 20537

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	04-30-2013	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	03-04-2010

RICHARDSON, WILLIAM H MD
5240 E. KNIGHT DR.
SUITE 112
TUCSON, AZ 85712-0000

Sections 304 and 1008 (21 USC 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IT IS NOT VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (4/07)

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

CME

MAR 1 1 2002

AZ MD Lic#: 18829 William H. Richardson, MD 1349

Renewal Fee: $450 **Late Fee: $800** (if postmarked after 04/30/2002)

CURRENT INFORMATION Please review and make corrections as necessary →	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS 5240 E Knight Dr Ste 112 Tucson AZ 85712-2122 **Phone #:** (520) 323-9682 **Fax #:** **E-Mail:**	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS** **Phone #:** **Fax #:** 323-9689 **E-Mail:**
MAILING ADDRESS 5240 E Knight Dr Ste 112 Tucson AZ 85712-2122	**MAILING ADDRESS**
HOME ADDRESS 5240 E Knight Dr Ste 112 Tucson AZ 85712-2122 Statute requires a home address and phone number (Street address) **Phone #:** (520) 323-9682 **Fax #:** (520) 323-9689 **E-Mail:**	**HOME ADDRESS** [redacted] **Phone #** [redacted] **Fax #:** N/A **E-Mail:** N/A **Cell Phone #:** N/A (Optional)

AMERICAN BOARD CERTIFICATIONS AND FIELDS OF PRACTICE:

	Certified?	Practicing?
GYN	N	Y
OBG	N	N

Make corrections if necessary

Select from the attached list of Self-Designated "Field of Practice" Codes

	Certified?	Practicing?
GYN	Y	Y
OB	Y	N

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? ☐ Yes ☒ No
3. Since your last renewal have you had hospital privileges revoked, denied, suspended or restricted? ☐ 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? ☐ 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? ☐ 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 safety practice medicine? [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________
   State________ Date of Denial________ Reason for Denial________
10. Within the past 5 years, have you been found guilty or entered into a plea of no contest to a felony, or misdemeanor involving moral turpitude in any state? **If yes, please attach an explanation and applicable court docket.** ☐ Yes ☒ No
11. Within the past 5 years, have you been named as a defendant in a malpractice matter currently pending or that resulted in a settlement or judgment against you? **If settlements or judgments in past 5 years, please attach a copy of the National Practitioner Data Bank report. Please include the claimant's name.** ☐ Yes ☒ No

If the answer is yes to any of the above questions, please provide a complete written explanation even if submitted with a previous renewal

I hereby certify, under penalty of perjury, that all information on this form is currently accurate. I also certify that during calendar year 2001, I have completed a minimum of 20 credit hours of continuing medical education as required by A.R.S. §32-1434 and A.A.C. § R4-16-101.

Signature of Licensee (Signature stamp will not be accepted)

2.4.02
Date

NOTE: PLEASE SUBMIT CME DOCUMENTATION WITH THE ENCLOSED CME AUDIT FORM

084

In

ARIZONA MEDICAL BOARD
2004 BIENNIAL MD LICENSE RENEWAL APPLICATION

Pd cc

AZ MD Lic#: 18829 William H. Richardson, MD

Renewal Fee: $500 $850 (If postmarked after 04/30/2004)

CURRENT INFORMATION
Please review and make corrections as necessary ⇨

OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS
PUBLIC ADDRESS & PHONE NUMBER
5240 E Knight Dr Ste 112
Tucson AZ 85712-2122

Phone #: (520) 323-9682 **Fax #:** (520) 323-9689
E-Mail:

MAILING ADDRESS
5240 E Knight Dr Ste 112
Tucson AZ 85712-2122

RECEIVED
MAR 18 2004
By

HOME ADDRESS
[redacted]

Phone #: [redacted] **Fax #:**
E-Mail:

CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS

Phone #: **Fax #:**
E-Mail:
MAILING ADDRESS

HOME ADDRESS

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

AMERICAN BOARD CERTIFICATIONS AND FIELDS OF PRACTICE:

	Certified?	Practicing?
OBG	1	False
GYN	1	True

Select from the attached list of Self-Designated "Field of Practice" Codes

Make corrections if necessary

	Certified?	Practicing?

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? .... [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 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. If malpractice cases are reported, please include: the case number, venue, plaintiff name, and attorney names/addresses/phone numbers.

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.

[signature] 3-15-04

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 MEDICAL BOARD
2006 BIENNIAL MD LICENSE RENEWAL APPLICATION

Ck # 152060

AZ MD Lic#: 18829 William H. Richardson, MD

Renewal Fee: $500 — $850 (if postmarked after 04/30/2006)

CURRENT INFORMATION Please review and make corrections as necessary →	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS **PUBLIC ADDRESS & PHONE NUMBER** 5240 E Knight Dr Ste 112 Tucson AZ 85712-2122	**OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS** William Richardson, MD No "H"
Phone #: (520) 323-9682 Fax #: (520) 323-9689 E-Mail:	Phone #: Fax #: E-Mail:
MAILING ADDRESS 5240 E Knight Dr Ste 112 Tucson AZ 85712-2122	**MAILING ADDRESS**
HOME ADDRESS [redacted]	**HOME ADDRESS**
Phone #: [redacted] Fax #: E-Mail:	Phone #: Fax #: E-Mail: Cell Phone #: (Optional)

AMERICAN BOARD CERTIFICATIONS AND FIELDS OF PRACTICE:

Select from the attached list of Self-Designated "Field of Practice" Codes

	Certified?	Practicing?
OBG	Y	N
GYN	Y	Y

Make corrections if necessary

	Certified?	Practicing?

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? [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, State____ Date of Denial____ Reason for Denial____ ☐ Yes ☑ No
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 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.

[signature] — Signature of Licensee (Signature stamp will not be accepted)

1.30.05 — Date

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

ARIZONA MEDICAL BOARD
2008 BIENNIAL MD LICENSE RENEWAL APPLICATION

AZ MD Lic#: 18829 William Richardson, MD

Renewal Fee: $500 $850 (if postmarked after 04/30/2008)

CURRENT INFORMATION Please review and make corrections as necessary™	CORRECTIONS
OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS PUBLIC ADDRESS & PHONE NUMBER 5240 E Knight Dr Ste 112 Tucson AZ 85712-2122	OFFICE ADDRESS/PRINCIPAL PLACE OF BUSINESS
Phone #: (520) 323-9682 Fax #: (520) 323-9689 E-Mail:	Phone #: Fax #: E-Mail:
MAILING ADDRESS 5240 E Knight Dr Ste 112 Tucson AZ 85712-2122	MAILING ADDRESS
HOME ADDRESS FEB 04 Phone #: E-Mail: Mobile #:	HOME ADDRESS Phone #: E-Mail: Mobile #: (Optional)

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?
OBG	Y	N
GYN	Y	Y

Make corrections if necessary INITIALS REQUIRED

	Certified?	Practicing?	Expiration Date	Initials Required
OBG	Y	N	12.31.08	W
GYN	Y	Y	12.31.08	W

If you don't verify the above fields by your initials the ABMS certification will be removed from your profile on the website.

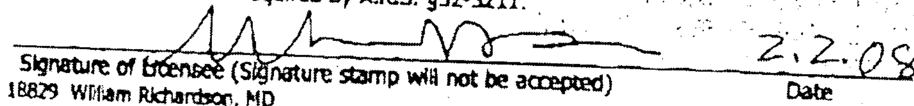
REQUEST FOR CHANGE IN LICENSE STATUS:

☐ **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 am a U.S. Citizen or a qualified/registered alien
- I have completed a minimum of 40 credit hours of continuing medical education during calendar years 2006 and 2007 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.

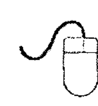


2.2.08

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

18829 William Richardson, MD

SEE REVERSE SIDE



Question	Yes	No
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.

18829 William Richardson, MD

INITIALS REQUIRED

BIENNIAL MD LICENSE RENEWAL APPLICATION

(Please Type in Spaces Provided)

CK 2053 $500

RECEIVED
FEB 26 2010
AZ MEDICAL BOARD

☒ **License Fee: $500** (if postmarked by due date)

☐ **$850** if postmarked 30 days after due date

BEFORE COMPLETING THIS RENEWAL FORM [illegible]

REMEMBER: *There is a $25 fee for processing a deficient renewal. Please double check your completed application before mailing.*

First Name: William **Initial:** H **Last Name:** Richardson

License Number: 18829

ADDRESSES: [illegible]

Practice Name: Tucson Women's Center

Office Address: 5240 E. Knight Drive Suite 112 **City:** Tucson **State:** AZ **Zip:** 85712

Email: [redacted] **Office Phone:** +1 (520) 323-9682 **Office Fax:** +1 (520) 323-9689

Mailing Address: 5240 E. Knight Drive Suite 112 **City:** Tucson **State:** AZ **Zip:** 85712

Home Address: [redacted] **City:** [redacted] **State:** [redacted] **Zip:** [redacted]

Home Phone: [redacted] **Mobile Phone:** [redacted]

PLEASE NOTE: *You are required to notify the Board in writing within 30 days of any change in office or home address and telephone number. A.R.S. §32-1435(B) & (D). There is a fine of $100 for failure to report change of address.*

AMERICAN BOARD OF MEDICAL SPECIALTY (ABMS) CERTIFICATIONS AND FIELDS OF PRACTICE [section instructions largely illegible due to scan noise]

Area of Interest	ABMS Certified?	Practicing?	Expiration Date (Or indicate if lifetime certificated)
OB/GYN	☑ Yes ☐ No	☑ Yes ☐ No	12/2011
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

PROOF OF CITIZENSHIP [section instructions largely illegible due to scan noise]

☒ **I am a U.S. Citizen or U.S. National.** (If you have not provided the Board with a copy of one of the documents listed in the Statement of Citizenship and Alien Status (i.e. birth certificate, passport, etc) since 2008, please submit a copy with your application.

☐ **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 an "Arizona Statement of Citizenship and Alien Status for State Public Benefits" form along with a copy of one of the listed approved supporting documents, such as an Alien Registration Card, Visa, etc.)

PROTOCOL FOR STORAGE, TRANSFER AND ACCESS OF PATIENT MEDICAL RECORDS

☑ I am aware that it is unprofessional conduct to fail to have a written protocol in place for the secure storage, transfer and access of patient medical records when a physician terminates or sells his/her practice and the medical records do not remain in the same physical location. I have a 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.

CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS

☑ I have completed a minimum of 40 hours CME during the two previous calendar years of renewal year as required by A.R.S. §32-1434 and A.A.C. §R4-16-101.

****Please do not submit proof of CME unless you received notice on your renewal that you are subject to a CME audit. If an audit was indicated, please submit the CME documentation with your completed renewal.*

REQUEST FOR CHANGE IN LICENSE STATUS [section instructions largely illegible due to scan noise]

☐ **I request INACTIVATION of my medical license.** I am not presently under investigation by the Board, the Board has not commenced 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 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, the Board may require me to pass the SPEX and any combination of physical, psychiatric, or psychological examinations or interviews it deems necessary to determine my ability to safely engage in the practice of medicine. A.R.S. §32-1431.

☐ **I request CANCELLATION of my medical license.** I am not presently under investigation by the Board, the Board has not commenced disciplinary proceedings against me, and I am no longer practicing medicine in Arizona.

QUESTIONNAIRE

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, license 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, or 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 contendre plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not the sentence was imposed or expunged? ☐ 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 that the response to any of the questions above is [illegible] concerning the above matters including any charge, date of such charge [illegible] jurisdiction, the result [illegible] and the disposition of such matters. In addition, you [illegible] submit photocopies of any corresponding documents such as complaint [illegible]

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 Claims, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale and 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.

First Name: William **Initial:** H **Last Name:** Richardson

License Number: 18829

CONFIDENTIAL QUESTIONNAIRE

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 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?

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

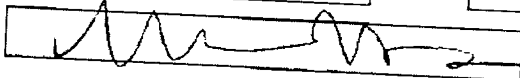
1. The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other healthcare providers, with or without the use of aids 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.

NOTE: In the event that the response [illegible]

Failure to properly answer these questions [illegible]

☑ **I ATTEST THAT ALL INFORMATION SUBMITTED ON AND WITH THIS RENEWAL APPLICATION IS TRUE.** This includes information and responses provided on all four pages of the renewal application, any corrections made to the enclosed physician profile, and any information provided on or submitted with the CME Audit Form.

First Name: William **Initial:** H **Last Name:** Richardson

Signature:  **License Number:** 18829

Questions?