Interview File Report 4/12/2012

Willie James Parker

Board Date	04/12/2012	**License#**	MD
Intended Location	Birmingham		
POB	Birmingham AL United States	**DOB**	10/18/1962
Original License	FLEX/IA	**Date**	03/19/1992

PreMed	Berea College	BA 86
Medical	State Univ Of Iowa Coll Of Homeopathic Med	6/86-5/90
Residency	University of Cincinnati Medical Center	7/90-6/94
Residency	University of California - San Francisco	7/00-6/01

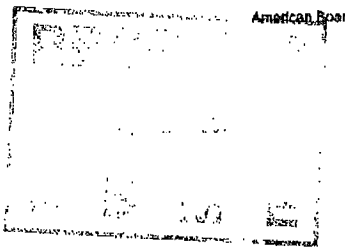
ALABAMA BOARD OF MEDICAL EXAMINERS/MEDICAL LICENSURE COMMISSION RECEIPT

Receipt Number: 885868
Reference: 2571
Staff: Jackie Baskin

Date of Receipt: 12/09/2011
Total Amount: $175.00

Receipted From (Individual)	GL Code	GL Description	Amount
Willie James Parker 2819 5th ST NE Washington, DC 20017	100-4101	100-4101 - License Application Fee	$175.00

Kenneth L. Noller, M.D.
Director of Evaluation
American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: (214) 871-1619
Fax: (214) 871-1943



February 29, 2012

Willie James Parker, M.D.
2819 5th Street, NE
Washington, DC 20017

Dear Doctor:

Congratulations! I am pleased to inform you that you have satisfactorily completed the 2011 Maintenance of Certification Part II assignments. You have earned 25 AMA Category 1 CME credits. These will be awarded by the American College of Obstetricians and Gynecologists (ACOG).

Documentation of completion of the MOC process will be furnished to the engraving company.

Your certification status in Obstetrics and Gynecology on February 29, 2012 is "active" The MOC process requires a new application and participation each year.

Please use this letter to provide documentation of your status for your hospitals. Please remember that you must re-apply for MOC each year. The application for the 2012 MOC process will be available through your ABOG Member Login page beginning in November, 2011 .

Sincerely yours,

Kenneth Noller, M.D.
Director of Evaluation

KLN

ABOG ID: 940869

ABO+G

Larry C. Gilstrap, III, M.D.
Executive Director
American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: (214) 871-1619
Fax: (214) 871-1943

December 20, 2011

State of Alabama Board of Medical Examiners
Attn: Licensing
PO Box 946
Montgomery, AL 36101-0946
United States

The below referenced physician is a Diplomate of the American Board of Obstetrics & Gynecology, Inc. (ABOG)

RE: Certification Status of:
Willie James Parker, M.D.

Obstetrics and Gynecology Certification

Original Certification Date: 11/15/1996
Certification Status: Valid through: 12/31/2012
Meeting Requirements of Maintenance of Certification: Yes

An individual becomes a Diplomate of ABOG when he/she has fulfilled all requirements, has satisfactorily completed the written and oral examinations and has been awarded ABOG's certifying diploma. Diplomas issued prior to 1986 for basic Ob/Gyn and November 1987 for subspecialties are unlimited. Diplomas issued in 1986 for basic Ob/Gyn and November 1987 for subspecialties, as well as all subsequent dates, are valid for a maximum of 10 years. The expiration date on a subspecialty diploma is the same as that of the Ob/Gyn diploma.

Sincerely yours,

Larry C. Gilstrap III, MD

Larry C. Gilstrap, M.D.
Executive Director

ABOG ID: 940869

A195367

WILLIE JAMES PARKER, MD, MPH, MSc
2819 5th Street, NE
Washington, DC 20017
Email: berean86wp@yahoo.com
Phone: 808-271-0260

December 21, 2011

Board of Medical Examiners
P.O. Box 946
Montgomery AL 36101-0946

To Whom It May Concern:

As requested per written communication related to my application, the following narrative is a summary of my professional activities not accounted for on my application for licensure in Alabama. I have listed activities from most present to prior.

EMPLOYMENT

2/2011- present	**Philadelphia Women's Center, Philadelphia, Pennsylvania.** Contract Physician. Responsible for clinical services. Duties include family planning services, resident education, and conduct abortion care.
7/2011- present	**Planned Parenthood, Metropolitan Washington, Washington DC.** Contract Physician. Responsible for clinical services. Duties include family planning services, resident education, and conduct abortion care.
6/ 2009-7/2011	**Planned Parenthood, Metropolitan Washington, Washington DC.** Medical Director. Responsible for clinical and laboratory services for this Affiliate operating five clinics in Maryland, Virginia, and the District of Columbia. Duties include family planning services, resident education, and conduct abortion care in the District of Columbia.
8/ 2008-5/2009	**Washington Hospital Center Residency in Obstetrics & Gynecology.** Director, Division of Family Planning and Preventive Services. Established family planning services, resident education, and conduct abortion care in the District of Columbia.

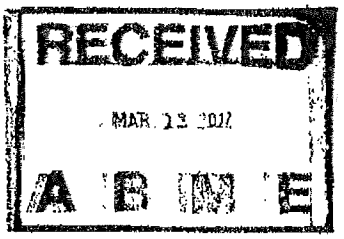
I remain available to submit other requirements as requested. Thank you.

MD, MPH, MSc

Willie J. Parker, MD, MPH, MSc

MARYLAND BOARD OF PHYSICIANS
P.O. Box 2571
4201 Patterson Avenue
Baltimore, MD 21215-0095
(410) 764-4777
Fax (410) 358-2252

March 6, 2012



Requested by: Medical Board of Alabama

The following is available under the Maryland Public Information Act, State Government Article, Section 10-617(h), regarding the following practitioner:

PARKER, WILLIE JAMES
2819 5TH STREET NE
WASHINGTON, DC 20017

License Number: D0069574

Date Issued: July 15, 2009

Current Status: Active

Expiration Date: September 30, 2013

Medical School: UNIV OF IA COLL OF MED

Licensed By: FLEX 1 and 2 Passed Within 5 Years

Specialty:

Charges:

Disciplinary Actions: NONE

No Maryland Health Claims Arbitration Office malpractice claims filed since July 1, 1986

Recd MD Bd AS

Suzanne Cox

Verification Clerk

03/06/2012

Date

This is a computer generated form which is acceptable by other states.
Licensing examination scores should be requested directly from the examining authority.

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov

VERIFICATION OF LICENSURE

This is to verify that the records of the State Medical Board of Ohio contain the following information for the indicated licensee as of 02/08/2012:

Identification Information

Name and Address:	Dr. Willie James Parker 635 Liberty Pointe Ann Arbor, MI 48103
Date of Birth:	10/18/1962
Place of Birth:	Birmingham, AL
School of Graduation:	**Des Moines University - Osteopathic Medical Center**
Date of Graduation:	05/04/90

License Information

Type of License:	Doctor of Medicine
License Number:	35. 063458
How Issued:	End Flex
Original Licensure Date:	05/29/1992
Expiration Date:	04/01/2010
Status:	INACTIVE
Formal Disciplinary Action:	No

Richard A. Whitehouse
Executive Director

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
P. O. Box 2649
Harrisburg, PA 17105-2649
www.dos.state.pa.us

January 20, 2012

CERTIFICATION OF LICENSE

This is to certify that the individual or business named below is licensed by the Department of State, Bureau of Professional and Occupational Affairs:

NAME:	WILLIE JAMES PARKER
LICENSE TYPE:	Medical Physician and Surgeon
LICENSE NUMBER:	MD441490
ORIGINAL LICENSURE DATE:	11/09/2010
EXPIRATION DATE:	12/31/2012
STATUS:	Active

The license is in good standing and the records indicate no derogatory information.

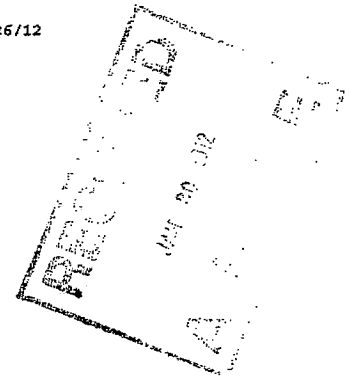
Katie Trues

SEAL

Commissioner
Bureau of Professional and Occupational Affairs

STATE OF HAWAII
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
PROFESSIONAL AND VOCATIONAL LICENSING DIVISION
P.O. BOX 3469
HONOLULU, HAWAII 96801

01/26/12



BOARD OF MEDICAL EXAMINERS
P O BOX 946
MONTGOMERY AL 36101

RE: VERIFICATION OF LICENSE/EXAM SCORES DATED 01/17/12 FOR WILLIE PARKER

BOARD/COMMISSION:	HAWAII MEDICAL BOARD
LICENSE TYPE:	PHYSICIAN
LICENSE IDENTIFICATION:	MD 11733
METHOD OF LICENSURE:	PASSED FLEX
DATE LICENSED:	10/11/01
LICENSE STATUS:	FORFEITED; NEEDS TO RESTORE
LICENSE EXPIRATION DATE:	01/31/10
DISCIPLINARY ACTION:	NONE

ACCORDING TO OUR COMPLAINT RECORDS WHICH DATE BACK TO 1985:

✓ NO DEROGATORY INFORMATION IS ON FILE.

__ THE ATTACHED INFORMATION IS ON FILE CONCERNING THIS LICENSEE.

CERTIFIED BY:

Constance D. Cabral

CONSTANCE CABRAL
EXECUTIVE OFFICER

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Health Professional
Licensing Administration

Dear Sir or Madam:

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

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

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

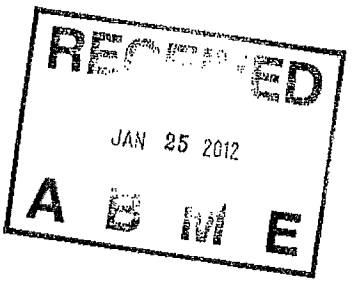
Unless stated below, there is **no** disciplinary action pending nor has any been taken.
NOTE: _____ If this blank has been checked, disciplinary action has been taken.
(See attached copies.)

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

SEAL

Certified By: Alma White DOH
Title: Health Licensing Specialist
Date: March 21, 2012

COMMONWEALTH of VIRGINIA



VERIFICATION

Re: **Willie James Parker**

From: Virginia Board of Medicine

Subj: Licensure Verification

Date: January 19, 2012

N14EZ

This is to certify that the above named individual was issued a license to practice by the Virginia Board of Medicine:

Licensed in/as a:	**Medicine & Surgery**
License:	**0101246274**
Issued on:	**08/13/2009**
Expires:	**10/31/2012 ***

This license has not been the subject of an administrative proceeding. If you have any questions, please call 804-367-4451.

The information above is the only verification provided by this board. If other information is needed, please do not hesitate to contact this office. To expedite the verification process, the above format is the standard format prepared for all professions regulated by this board.

Verifications may also be obtained from our website at www.dhp.virginia.gov or our interactive phone system at 804-270-6836 with fax back option.

* The expiration date of 1956 indicates that there is no recorded date of expiration for this license, and that it expired sometime prior to 1980.

Sincerely,

M. Ola Powers

Deputy Executive Director, Licensing
Virginia Board of Medicine

NOTE: The Board of Medicine no longer provides a raised seal on this document.

State of California Department of Consumer Affairs

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

January 24, 2012

TO WHOM IT MAY CONCERN:

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

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

This license information was last updated on: 01/23/2012

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

Curtis J. Worden

Curtis J. Worden
Chief of Licensing

JENNIFER M. GRANHOLM
Governor

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
Director

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 01/24/2012

NAME: Willie James Parker **BIRTHDATE:** 10/18/1962

ADDRESS: 635 Liberty Pointe Dr
Ann Arbor MI 481030000

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

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

OBTAINED BY: Endorsement - Licensed >= 10 Years

EXAM DATE	EXAM TYPE	EXAM SCORE OR RESULT

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

This license information was last updated on: 01/22/2012

App C

STATE OF IOWA

IOWA BOARD OF MEDICINE

CELEBRATING 25 YEARS

MARK BOWDEN
EXECUTIVE DIRECTOR

January 24, 2012

Verification of Licensure

Alabama State Board of Medical Examiners
P O Box 946
Montgomery, AL 36104

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

NAME:	Willie James Parker, MD
DATE OF BIRTH:	10/18/1962
LICENSE NUMBER:	28574
LICENSE TYPE:	Permanent
ISSUE DATE:	03/19/1992
EXPIRATION DATE:	10/01/1994
HOW OBTAINED:	FLEX
STATUS:	Inactive
DISCIPLINARY ACTION:	No
HISTORY OF INVESTIGATION:	*See below*

This license information was last updated on: 01/22/2012

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

Sincerely,

Rachel Davis
Licensing Assistant

IA 8880

400 SW 8th Street, Suite D Des Moines, IA 50309-4686 Phone 515-281-5171 Fax 515-242-5908 www.medicalboard.iowa.gov

The Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039
Telephone: (817) 868-5000
Fax: (817) 868-5099

Physician Information Profile

This report is compiled exclusively for:

Name: **Willie James Parker**

DOB: **1962**
Packet ID: **91393**
Recipient: **Alabama State Board of Medical Examiners**

NOTICE:

The Federation Credentials Verification Service (FCVS) was retained by the above referenced physician to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

Table of Contents

Section I

FCVS Reports

FEDERATION CREDENTIALS VERIFICATION SERVICE

Physician Information Report

Identity:

Name:	**Willie James Parker**	
Other Name Used:	N/A	
Gender:	**Male**	
Date of Birth:	**/1962**	
Place of Birth:	**Birmingham, AL USA**	
Current Address:	**2819 5th Street NE** **Washington, DC 20017**	
Permanent Address:	**Same**	
Telephone Numbers:	Bus:	**734-930-5618**
	Fax:	**N/A**
	Home:	**808-271-0260**
	Other:	**N/A**
Physical Description:	Height:	**5' 11"**
	Weight:	**230 lbs**
	Eye Color:	**Brown**
	Hair Color:	**Black**
Physical Marks:	Description:	**N/A**
	Location:	**N/A**

Premedical Education (Reported by physician. Not verified by FCVS):

Institution:	**Berea College, Berea, KY 40404**
Dates of Attendance:	**08/1981 - 05/1986**
Degree Conferred/Issued:	**Bachelor of Arts**

Medical Education:

Medical School:	**Carver College of Medicine at University of Iowa** **Office of the Registrar** **1 Jessup Hall** **Iowa City, IA 52242**
Dates of Attendance:	**06/09/1986 - 05/04/1990**
Date Degree Conferred/Issued:	**05/04/1990**
Degree Conferred/Issued:	**Doctor of Medicine**

Unusual Circumstance: None

Graduate Medical Education:

Institution: **University of Cincinnati Medical Center**
Department of Obstetrics and Gynecology
PO Box 670526 - 231 Albert Sabine Way
Cincinnati, OH 45267-0526

Training Level: 1-4
Program Type: **Residency**
Specialty/Subspecialty: **Obstetrics and Gynecology**
Dates of Attendance: **07/01/1990 - 06/30/1994**
Completion: **Yes**
Accreditation: **ACGME**

Unusual Circumstance: **None**

Institution: **University of California San Francisco School of Medicine**
Departmentof Occupational Medicine
Box 0843
San Francisco, CA 94143

Training Level: 6
Program Type: **Residency**
Specialty/Subspecialty: **Preventive Medicine**
Dates of Attendance: **07/01/2000 - 06/30/2001**
Completion: **Yes**
Accreditation: **ACGME**

Unusual Circumstance: **None**

Institution: **University of Michigan Medical School**
Department of Obstetrics and Gynecology
1500 East Medical Center Drive
L4510 Women, SPC 5276
Ann Arbor, MI 48109

Training Level: 7
Program Type: **Fellowship**
Specialty/Subspecialty: **Obstetrics and Gynecology**
Dates of Attendance: **07/01/2006 - 06/30/2008**
Completion: **Yes**
Accreditation: **NONE**

Unusual Circumstance: **None**

Fifth Pathway:

N/A

Examination History:

Licensure Examinations: **FLEX - Component 1**
FLEX - Component 2

Board Action:

A Report of the results from a search of the Board Action Data Bank is enclosed.

Credentials Analysis Report

The Credentials Analysis Report is a comparative report of a physician's credentials as reported to FCVS by the physician applicant and the primary source (Medical School, PGT program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Physician Identification:

Name: Willie James Parker
DOB: '1962

Packet ID: 91393
Request ID: 24306036

OMISSIONS

There are none identified.

DISCREPANCIES

There are none identified.

MISCELLANEOUS INFORMATION

Miscellaneous 1:

Section of Profile: **Post-Graduate Education**

Issue: The applicant and University of Cincinnati Medical Center do not report the same program type for 07/01/1990 to 06/30/1994.

Follow-Up: FCVS does not follow up on program type based on the definition of a resident per ACGME (A physician at any level of GME in a program accredited by the ACGME is considered a resident).

Miscellaneous 2:

Section of Profile: **Post-Graduate Education**

Issue: The applicant and University of California San Francisco School of Medicine do not report the same program type for 07/01/2000 to 06/30/2001.

Follow-Up: FCVS does not follow up on program type based on the definition of a resident per ACGME (A physician at any level of GME in a program accredited by the ACGME is considered a resident).

Miscellaneous 3:

Section of Profile:	**Continuity of Education**
Issue:	Time periods of 6 months or more in which the physician did not participate in activities verified as part of the Physician Information Profile were identified during medical education between: Verified postgraduate programs
Follow-Up:	Included immediately after the Credentials Analysis Report is one of the following documents which were obtained from the applicant to explain the interruption: Explanation of Activities During Medical Education Form Curriculum Vitae FCVS Application page(s) Or a Written Explanation from the Applicant

End of report for Willie James Parker

Packet Id: 91393 Request Id: 24306036 Report Created By: DSAWAF

Federation of
STATE
MEDICAL
BOARDS

EXPLANATION OF OTHER ACTIVITIES DURING MEDICAL EDUCATION

Please provide a complete, specific explanation regarding any postgraduate training performed in a country other than the US or Canada, externships, observation, staff positions etc and activities other than postgraduate training in which you engaged between the beginning of your medical education and the final year of your US postgraduate training. Do not include Canadian programs.

Dates should be reported in month/year (mm/yyyy) format.

1. From: 7/1994 (Month Year) To: 6/1997 (Month Year)
   Activity: **National Health Service, Merced, California.**
   Placement Site: Golden Valley Health Centers Inc.
   Staff Obstetrician and Gynecologist. Practiced full range of general obstetrics and gynecology in a medically under-served area. Range of responsibilities clinically included limited "high risk" obstetrics and basic infertility evaluation and treatment.

2. From: 7/1997 (Month Year) To: 6/1998 (Month Year)
   Activity: **Harvard School of Public Health, Boston, Massachusetts.**
   Master's of Public Health. Degree awarded June, 1998

3. From: 7/1998 (Month Year) To: 6/2000 (Month Year)
   Activity: **Centers for Disease Control: Epidemic Intelligence Service, Atlanta, Georgia.**
   Placement Site: CA Department of Health Services, Maternal Child Health Branch, Sacramento CA. EIS Officer. Conducted acute disease outbreak investigation, analytic research, and provided technical assistance to local and regional health departments.

4. From: 7/2000 (Month Year) To: 6/2001 (Month Year)
   Activity: **Preventive Medicine Residency. University of California, San Francisco- University of California, Berkeley Joint Program, San Francisco, CA.** Residency in Preventive Medicine. Diplomate.

5. From: 5/2001 (Month Year) To: 11/2001 (Month Year)
Activity: **California Department of Health Services, Sacramento, California.** Chief, Policy and Programs, Maternal Child Health Branch. Coordinated statewide identification and monitoring of resources associated with care of women and children; supervised a staff of 30 and accountable for a multimillion dollar budget; wrote reports as required by legislature.

6. From: 12/2001 (Month Year) To: 1/2002 (Month Year)
Activity: vacation and travel between jobs

7. From: 1/2002 (Month Year) To: 5/2006 (Month Year)
Activity: **Queen's Medical Center, Honolulu, Hawaii**
Attending Physician, Queen Emma Clinics.

8. From: 5/2006 (Month Year) To: 6/2006 (Month Year)
Activity: vacation and travel between jobs.

Willie J. Parker (Applicant Name) June 5, 2008 (Date)

By typing my name above, I hereby certify that I am the individual referenced in the FCVS application and that I agree to the terms and conditions set forth therein. Furthermore, I acknowledge that I have answered all questions and reported all information on this application page truthfully and completely.

The Federation of State Medical Boards
of the United States, Inc
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817)868-4000
FAX (817)868-4099

BOARD ACTION CLEARANCE REPORT

November 08, 2011

Attn: Tracy Bevers
FCVS
Tracy Bevers
400 Fuller Wiser Rd., #209
Euless, TX 76039

Re: Board Action Query Dated: November 08, 2011
Your Reference Number: fcvs-jyw
FSMB Batch Number: BQ1989277

The following is a final report of the search results from the Board Action Data Bank as of November 08, 2011 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of November 08, 2011

Item	Name	DOB	School	Yr/Grad	Request ID
13	Parker, Willie James	10/18/1962	016010	1990	24402333

LICENSE HISTORY
State Board
CALIFORNIA
DC
HAWAII
IOWA
MICHIGAN
OHIO
PENNSYLVANIA
VIRGINIA

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

AMERICAN BOARD OF MEDICAL SPECIALTIES
VERIFICATION OF CERTIFICATION

As of: 11/9/2011

State Queried For:	Alabama State Board of Medical Examiners
Physician Name:	Willie James Parker
Date of Birth:	10/18/1962
Year of Graduation:	(Doctor of Medicine)
Social Security Number:	424-90-4371
ABMSU ID:	552659

Certification:

Board:	Obstetrics and Gynecology
Specialty:	Obstetrics and Gynecology
Status:	ACTIVE
Initial Certification:	11/15/1996

All information on the ABMS report is based on a search of data shared with the FSMB by the American Board of Medical Specialties. For some physicians the biographic data in the ABMS database is incomplete and is not included in the shared data. FCVS is unable to verify specialty certification on these physicians. FCVS does not follow up with the applicant or ABMS on any missing or discrepant information.

Section II

Identity

Federation of STATE MEDICAL BOARDS

Affidavit and Release and Authorization for Release of Information, Documents and Records

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the "Instructions for Completing the FCVS Application" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I waive confidentiality, authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to my FCVS Physician Information Profile being mailed.

Parker, MD, MPH

Parker, MD, MPH

Applicant's Signature (must be signed in the presence of a notary)

Parker

Applicant's Printed Last Name

Willie James

Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

5/12/08 Date of Signature

/1962 Date of Birth

Applicant SSN

NOTARY

Your seal or stamp must be partly upon the photograph.

State of MICHIGAN County of WASHTENAW

SUBSCRIBED AND SWORN TO before me this 12th day of MAY, 20 08

My commission expires: 01-31-2012

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature:

I certify that on the date set forth above the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

91397

Section III

Medical Education

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

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

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

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of Iowa College of Medicine

Complete Address:

Street Address: 1216 MERF

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

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

Premedical Education:

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

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

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

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

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

This individual (check one):

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

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

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

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

Signature: Larissa Heimer

Title: Student Programs & Records

Date of Signature: 6-9-08

Phone: (319) 335-6823 **Fax:** (319) 335-8643

Email: annette-griffin@uiowa.edu

VERIFICATION OF MEDICAL EDUCATION

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

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

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

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

   Please Specify: _____

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

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

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

   Please specify reason: _____

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

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

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

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

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

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

Medical Education

School	016010 - University of Iowa College of Medicine
Dates	07/1986 to 05/1990
Clinical Training	*No information reported.*
Grad Date	05/04/1990
Degree	MD

Completed clinical clerkship in a country other than where my medical school was located: N

Unusual Circumstances:

Interruptions: N
Probation: N
Disciplined: N
Negative Reports: N
Limitations: N

Attended a Fifth Pathway Program: N

THE UNIVERSITY OF IOWA

(Founded as the State University of Iowa in 1847)

IOWA CITY IOWA 52242-1316

Office of the Registrar

OFFICIAL TRANSCRIPT

PRINT DATE 06/03/08 PAGE 1

UNIVERSITY NUMBER 00 26 33 07 COLLEGE M 4

PARKER WILLIE JAMES
635 LIBERTY POINTE DR
ANN ARBOR MI 48103

DEPT 60M MEDICINE
MAJ(S)

COURSE TITLE	DEPT	COURSE	SEM HR	GRADE
BEREA COL KY				
1981-86 BA 1986				
COLLEGE OF MEDICINE				
SUMMER SESSION 1986				
GEN HISTOL MED STS	060	105	04	P
1 SEMESTER 1986-87				
BIOSTATISTICS	063	110	01	P
HUMAN DIMEN IN MED	115	102	01	P
MEDICAL EMBRIOLOGY	060	104	01	P
BIOCHEM MED STUDENT	099	163	06	P
GROSS HUM ANAT MEDS	060	103	07	P
2 SEMESTER 1986-87				
GEN PATH MED STU	069	201	03	P
MED MICROBIOLOGY	061	103	07	P
MEDICAL PHYSIOLOGY	072	212	06	P
MEDICL NEUROSCIENCE	050	284	04	P
1 SEMESTER 1987-88				
SPANISH HLTH PROF	035	008	04	P
PREVENTIVE MEDICINE	063	109	03	P
SIST PATH MED STU	069	202	10	P
PHARMACOLGY MEDICAL	071	105	05	P
2 SEMESTER 1987-88				
INTRO CLINICAL MED	050	111	12	P
INTRO CLINICAL MED	050	111	08	P
YR 1988-89 JR CLKSHP				
PRECPTRSHP FAM PRAC	115	300	02	P
CLINICAL ANESTHESIA	116	005	02	P
CLIN OBSTET & GYN	066	004	06	P
CLIN DERMATOLOGY	062	001	02	P
CLINICAL NEUROLOGY	064	011	02	P
CLINICAL PEDIATRICS	070	002	06	P
CLIN OTOLARYNGOLOGY	068	003	02	P
CLINICAL PSYCHIATRY	073	005	06	P
CLINICAL SURGERY	075	006	06	P
CLIN ORTHOPAEDICS	076	002	02	P
CLIN INTERNAL MED	078	101	09	P
CLINICAL UROLOGY	079	104	02	P
SUMMER SESSION 1989				
GEN MED GUNDERSEN	078	002	04	P
CLIN INFEC DISEASE	078	550	04	P
1 SEMESTER 1989-90				
SR SEL FAM PRACTICE	115	424	04	P
CLINICAL RADIOLOGY	074	001	04	P
EMER RM-OTPT CLINIC	115	402	04	P
ADV HUMAN ANATOMY	060	232	04	P
GYNECOL ONCOLOGY	066	010	04	P
2 SEMESTER 1989-90				
DERMATOL ELECTIVE	062	002	04	P
ELECTROCARDIOGRAPHY	078	304	02	P
CLIN PHAR THERA LEC	078	380	02	P
DOCTOR OF MEDICINE DEGREE				
CONFERRED 05-04-90				

Undergraduate students must consult the degree evaluation for hours earned toward degree.

U OF I CUM 9/1/93 T2C TRANSFER CUM TOTAL CUM 165

SEAL VERIFIED

RAISED SEAL NOT REQUIRED

This Official University transcript is printed on SCRIPT-SAFE security paper.

Pre-Printed White Signature

University Registrar

Laser Produced Signature

UI F1458H 10/02

THE NAME OF THE UNIVERSITY APPEARS IN WHITE PRINT ACROSS THE FACE OF THIS DOCUMENT

DEPARTMENT COURSE CODE NUMBERS

006 College of Business Administration
06A Accounting
06B Business Administration
06E Economics
06F Finance
06J Management and Organizations
06K Management Sciences
06L Industrial Relations & Human Resources
06M Marketing
06N MBA Program
06T Business Administration Non-Departmental

College of Dentistry
061 Fixed Prosthodontics
062 Operative Dentistry
063 Endodontics (Dental Technology until 1977)
064 Prosthodontics
065 Oral Pathology (prior to 1976)
066 Oral Pathology, Radiology & Medicine (effective Summer 1981)
067 Oral & Maxillofacial Surgery
068 Dental Hygiene (Oral Surgery until 1965)
069 Orthodontics
090 Pediatric Dentistry
092 Periodontics
093 Oral Biology
111 Preventive & Community Dentistry
112 Dentistry Non-Departmental
114 Family Dentistry
151 Oral Science

007 College of Education
07A Adult Education
07C Counselor Education
07D Educational Administration
07E Early Childhood & Elementary Education
07E Elementary Education (effective Summer 1965)
07F Social Foundations
07H Higher Education
07M School Psychology
07P Educational Psychology, Measurement & Statistics
07S Secondary Education
07T Teacher Corps
07U Special Education
07V Educational Media
07W Instructional Design & Technology
07X Educational Interdivisional

College of Engineering [illegible]
prior to Fall 1976 and beginning [illegible]
051 Biomedical Engineering ([illegible] until 1976)
052 Chemical & Biochemical Engineering
053 Civil & Environmental Engineering
055 Electrical & Computer Engineering
056 Industrial Engineering
057 Engineering Core Courses
058 Mechanical Engineering
059 Mechanics and Hydraulics

College of Engineering
(Fall 1976 to Fall 1984)
All courses are designated with a 5 in the first digit. The third digit of the course prefix denotes the academic program for which the course is offered.
Third Program Digit
0 Undergraduate Engineering Core
1 Biomedical Engineering
2 Chemical & Materials Engineering
3 Civil and Environmental Engineering
4 Environmental Engineering
5 Electrical & Computer Engineering
6 Industrial & Management Engineering
7 Division Specialty Courses
8 Mechanical Engineering
9 Mechanics and Hydraulics

091 College of Law

College of Liberal Arts
BGS Bachelor of General Studies
BLS Bachelor of Liberal Studies
00L Iowa Lakeside Laboratory
000 Non-Departmental Courses
001 Art
01A Fundamentals
01B Elements of Art
01C Ceramics
01D Design
01E Art Education
01F Drawing
01G Metalworking and Jewelry
01H Art History
01J Multimedia & Video Art
01K Painting
01L Photography
01M Printmaking
01N Sculpture
01P Art Interdepartmental
01S Art Studio
01X Papermaking
01Y Studio
002 Biological Sciences (Botany until Fall 1982)
003 Speech Pathology & Audiology
004 Chemistry
005 Child Behavior & Development
006 Professions
008 English
08G Literature - General Education
08L English Language & Linguistics Instruction
08P English Professional
08W English Writing
009 French
010 Rhetoric (Basic Skills Courses until Fall 1982)
011 Interdisciplinary Courses (Core Courses until 1969)
012 Geology
013 German
13D Dutch
014 Greek
015 Open Major
016 History
16A American History
16E European History
16W World History
017 Home Economics
018 Italian
019 Journalism & Mass Communication
020 Latin
021 Library & Information Science
22A Applied Mathematical & Computational Sciences
22C Computer Science
22M Mathematics
22S Statistics & Actuarial Science
023 Military Science
23A Aerospace Military Studies
024 Museum Studies
025 Music
026 Philosophy
027 Exercise Science
028 Sport, Health, Le[illegible]ysical Studies
28D Dance
28S Physical Education [illegible]
029 Physics and Astronomy
030 Physical Science
031 Psychology
032 Religion
033 Literature, Science & the Arts
034 Sociology
035 Spanish
036 Communication Studies
36B Broadcasting and Film
36C Communication
36D Production Studies
36F Film Studies
36M Media Studies
36R Rhetorical Studies
36T Dramatic Art (Theatre)
037 Biology (Zoology until 1982)
038 Portuguese
039 Asian Languages and Literature
39J Japanese
041 Russian
41S Russian, East European & Eurasian Studies
042 Social Work
044 Geography
045 American Studies
047 Global Studies Program
048 Comparative Literature
48W International Writing Program
049 Theatre Arts
097 Science Education
098 Social Studies
102 Urban & Regional Planning
103 Linguistics
104 Leisure Studies
108 Center for the Book
113 Anthropology
122 Communication Studies
127 Genetics
129 African-American World Studies
130 Latin American Studies
131 Women's Studies
136 Quality Management & Productivity
137 Dance
138 Physical Education
139 Physical Education Elective
140 Unified Program
141 African Studies Program
142 Molecular Biology
143 Honors Program
144 Philosophies & Ethics of Politics, Law & Economics
145 Interdepartmental Studies
149 American Indian & Native Studies
150 Third World Development Support
152 Global Health Studies
153 Aging Studies Program
154 Sexuality Studies
156 American Sign Language
158 Environmental Studies
160 Rhetorics of Inquiry

College of Medicine
050 Medicine Non-Departmental
060 Anatomy
061 Microbiology
062 Dermatology
063 Preventive Medicine & Environmental Health
064 Neurology
065 Human Nutrition
066 Obstetrics and Gynecology
067 Ophthalmology
068 Otolaryngology—Head & Neck Surgery
069 Pathology
070 Pediatrics
071 Pharmacology
072 Physiology & Biophysics
073 Psychiatry
074 Radiology
075 Surgery
076 Orthopaedic Surgery
077 Radiation Biology
078 Internal Medicine
079 Urology
080 Hospital & Health Administration
099 Biochemistry
100 Occupational Therapy
101 Physical Therapy
113 Family Practice
116 Anesthesiology
117 Physician Assistant Program
132 Neuroscience
143 Immunology

096 College of Nursing

046 College of Pharmacy

Policies and Regulations Governing Official Records
The University of Iowa - Iowa City, Iowa 52242

Student Records are confidential records. Transcripts, therefore, are issued only at the request of the student or with his/her permission.

Entrance and Transferred Credits. The transcript includes only work attempted at the University of Iowa unless the work undertaken in another institution has been evaluated and credit accepted by transfer. Course grades are not indicated for transferred credits.

Academic Dismissal and Probation. A student is assumed to be in good standing unless otherwise indicated. Academic Dismissal from a college will result in a notation of "Not permitted to register" and is in effect until the student is either "Permitted to register" or admitted to another college within the University. Probationary status is determined by the individual College and is in effect until the student is returned to good standing.

Length of Term, Student Load, etc. A semester is approximately sixteen weeks. The unit of instruction is the semester hour, which consists of the equivalent of 750 minutes of lecture work or 1500 minutes of laboratory work for a semester.

Course Level. Course numbers are classified as follows: Below 100 - for undergraduates; from 100-199 - for undergraduates and graduates; 200 or above - for graduates.

Class Rank. The University of Iowa does not calculate class rank.

Grade-Point Average. In computing grade-point average for the Graduate College and colleges of Dentistry, Law, and Medicine, only the University of Iowa courses are used.

Current Grading System
(Plus/Minus system effective Summer 1988)

Pass Grades: A, B, C, D.
Grade points:
A+ = 4.33
A = 4.00
A- = 3.67
B+ = 3.33
B = 3.00
B- = 2.67
C+ = 2.33
C = 2.00
C- = 1.67
D+ = 1.33
D = 1.00
D- = 0.67
H = Honors
H- = Near Honors
P = Pass
S = Satisfactory
The cumulative grade-point average is truncated so as not to exceed 4.00.

Non-pass Grades:
F = Fail
N = Non-pass
U = Unsatisfactory

Other Symbols:
I = Incomplete
X = Excused
W = Withdrawn
O = No Grade Reported
R = Registered no grade required
≠ = Changed grade
+ = Undergraduate honors section
# = Grade not included in GPA

Graduate Credit: No graduate degree credit for courses numbered below 100 or with the grade of D or lower.

Colleges and Schools		Pass Marks						Nonpass Marks		
College of Business Administration (formerly College of Commerce)	1967-1980	A	B	C	D		P	F		
	From 1981	A	B	C	D		PS	F	N	
College of Dentistry	1964-1974	A	B	C	D		P	F		
	1975	H					P	F		
	1976-1977	A	B	C	D			F		
	From 1978	A	B	C	D	R	S	F		
College of Engineering (formerly Applied Science)	1964-1956	A	B	C	D			F		
	1957-1974	A	B	C	D		P	F		
	1975-1980	A	B	C	D	R	P	F		
	From 1981	A	B	C	D	R	PS	F	N	
Graduate College *Not accepted toward a graduate degree	1943-1965	A	B	C	D*	R		F		
	From 1966	A	B	C	D*	R	S	F	U	
College of Law *Describes the lower limit for equivalent letter grade	1965-1972	85*	75*	65*	60*		P	F	56-59	OE
	1973-1983	85*	75*	65*	60*	R	P	F	50-59	O
	1984-2004	85*	70*	65*	60*	R	P	F	50-59	O
	From 2004	3.5*	2.5*	2.0*	1.7*	R	P	F,U		
College of Liberal Arts	1950-1973	A	B	C	D		P	F		
	1974	A	B	C	D		PS	F		
	1975-1980	A	B	C	D	R	PS	F		
	From 1981	A	B	C	D	R	PS	F	N	
College of Medicine	1964-1972	H					P	F		
	1973-1996	H				R	P	F		
	From 1997	H	P			R	P	F		
		H-								
College of Nursing (formerly School of Nursing)	1954-1966	A	B	C	D			F		
	1967-1974	A	B	C	D		P	F		
	1975-1980	A	B	C	D	R	P	F		
	From 1981	A	B	C	D	R	PS	F	N	
College of Pharmacy	1964-1968	A	B	C	D			F		
	1969-1980	A	B	C	D		P	F		
	From 1981	A	B	C	D		PS	F	N	

TO TEST FOR AUTHENTICITY: The face of this document has a blue background and the name of the institution appears in small print. Apply fresh liquid bleach to the blue background. If authentic, the paper will turn brown.

ADDITIONAL TEST: When photocopied, the word COPY appears prominently across the face of the entire document. ALTERATION OR FORGERY OF THIS DOCUMENT MAY BE A CRIMINAL OFFENSE! A black and white document is not an original and should not be accepted as an official institutional document. If you have additional questions about this document, please contact University of Iowa Office of the Registrar at (319) 335-0230 or Fax (319) 335-1999.

UI F1458K - 02/05

The University of Iowa

ON THE RECOMMENDATION OF THE FACULTY OF THE

College of Medicine

AND UNDER THE AUTHORITY OF THE BOARD OF REGENTS
THE UNIVERSITY OF IOWA HAS CONFERRED THE DEGREE OF

Doctor of Medicine

UPON

Willie James Parker

WHO HAS HONORABLY FULFILLED ALL THE REQUIREMENTS PRESCRIBED
BY THE UNIVERSITY FOR THIS DEGREE

AWARDED AT THE UNIVERSITY AT IOWA CITY IN THE STATE OF IOWA
THIS FOURTH DAY OF MAY, NINETEEN HUNDRED AND NINETY.

PRESIDENT OF THE STATE BOARD OF REGENTS

PRESIDENT OF THE UNIVERSITY

DEAN OF THE COLLEGE

[redacted]

This is to certify this is a true copy of the original diploma awarded on May 4, 1990.

Jean Lantz, M. A.
Director of Student Programs and Records

Date

SEAL
VERIFIED

Section IV

Graduate Medical Education Training

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

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

Verification of Postgraduate Medical Education

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

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

Verification For:

Name: **Parker, Willie James**

DOB: [illegible] **1962**

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

Program Participation:

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

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

Report Internships, Residencies and Fellowships separately.

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

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

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

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

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

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

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

Please explain any "Yes" response from above:

____

____

Certification:

ELECTRONIC SEAL VERIFIED

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

Name: Arthur Ollendorff Signature: Arthur Ollendorff

Title: Residency Program Director Date of Signature: 10/15/08

Tel: 513-558-2860 Fax: 513-558-6138 E-Mail: ollendal@ucmail.uc.edu

Postgraduate Medical Education
University Hospital

Hospital University Hospital

Affiliated School University of Cincinnati College of Medicine
4511 Medical Sciences Building
231 Albert B. Sabin Way, M.L. 0526
Cincinnati, OH 45267-0526
USA

Unusual Circumstances:

Interruptions: N
Probation: N
Disciplined: N
Negative Reports: N
Limitations: N

PGY

Year(s):1-4 Internship/Residency: Complete?: Yes
Obstetrics and Gynecology
Dates: 07/1990 to 06/1994

University of Cincinnati Medical Center
University of Cincinnati Hospital

This is to certify that

WILLIE J. PARKER, M.D.

served as a

RESIDENT

in

OBSTETRICS & GYNECOLOGY

July 1, 1990 - June 30, 1994

In witness whereof, *we have hereunto affixed our names and attached the official seals of the University and Hospital.*

Dean, College of Medicine

CEO/Director, University Hospital

Professor and Chairman, Department of Obstetrics and Gynecology

Federation of STATE MEDICAL BOARDS

F[redacted]ation Credentials Verification Service (FCV[redacted])
Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

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

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

Verification For:

Name: **Parker, Willie James**

DOB: 1962
Individual's Name on Record (If different from above): _____

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

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

Report Internships, Residencies and Fellowships separately.

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

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

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

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

Unusual Circumstances:
Check the correct response. Omitted responses require written explanation.

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

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

Please explain any "Yes" response from above:

ELECTRONICALLY SEAL VERIFIED

Certification:

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

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

Name: George W. Rutherford, M.D. Signature: *George W. Rutherford, M.D.*
Title: Program Director Date of Signature: June 12, 2009
Tel: (415) 597-9108 Fax: (415) 597-8299 E-Mail: grutherford@psg.ucsf.edu

Rev 09/07/05 Packet ID 91393 Request ID: 19361582 IFM CODE[23335]

Federation of
STATE
MEDICAL
BOARDS

Full Name: Willie James Parker
Pact ID: 91393

PROVIDED BY APPLICANT

20. Postgraduate Medical Education

List all of the postgraduate medical education programs you attended in chronological order. **Use one page per institution.**

IMPORTANT:

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

If your postgraduate year is currently in progress, indicate the EXPECTED completion date in the "To" field.

Report internships, residencies, fellowships and research programs separately.

Use one section per department.

(PGY) – Postgraduate years is also known as postgraduate training level.

If a break of six (6) months or more occurred between any of your postgraduate training activities, please provide a written explanation outlining your activities during this period on the "Explanation of Other Activities" form.

Complete name of hospital where training was conducted (Do not abbreviate).
University of California San Francisco

Complete name of affiliated university or college (Do not abbreviate).
University of California San Francisco Prevention Science Group
Address line 1
50 Beale St. Suite 1200
Address line 2
San Francisco
City
CA
State/Province
USA
Country
94105 - 1823
ZIP/Postal Code

PGY:____
- [ ] Internship
- [ ] Residency
- [ ] Chief Residency
- [x] Fellowship
- [ ] Research

Preventive Medicine
Specialty/Subspecialty

From: 07 /2000 To: 06 /2001

Successfully Completed? [x] Yes [ ] No [ ] In Progress

PGY:____
- [ ] Internship
- [ ] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

____
Specialty/Subspecialty

From: ___/___ To: ___/___

Successfully Completed? [ ] Yes [ ] No [ ] In Progress

PGY:____
- [ ] Internship
- [ ] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

____
Specialty/Subspecialty

From: ___/___ To: ___/___

Successfully Completed? [ ] Yes [ ] No [ ] In Progress

PGY:____
- [ ] Internship
- [ ] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

____
Specialty/Subspecialty

From: ___/___ To: ___/___

Successfully Completed? [ ] Yes [ ] No [ ] In Progress

Unusual Circumstances (check yes or no):

Did you ever take a leave(s) of absence or break(s) from your medical education?	[ ] Yes [x] No
Were you ever placed on probation?	[ ] Yes [x] No
Were you ever disciplined or placed under investigation?	[ ] Yes [x] No
Were any negative reports for behavioral reasons ever filed against you?	[ ] Yes [x] No
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	[ ] Yes [x] No

Please explain any "YES" response from above:
____

Signature: *Willie J. Parker, MD, MPH, MSc* Date: 05/21/09

By typing my name above, I certify that I am the individual referenced in the FCVS application and that I agree to the terms and conditions set forth therein. Furthermore, I acknowledge that I have answered all questions and reported all information on this application page truthfully and completely.

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

Federation Place, P.O. Box 619960, Dallas, TX 75261-9960
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

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

Attention: Program Director
Affiliated University: ____

Verification For:

Name: **Parker, Willie James**

DOB: ____/1962
Individual's Name on Record (if different from above): ____

Program Participation:

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

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

Report Internships, Residencies and Fellowships separately.

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

PGY: VII
☐ Internship
☐ Residency
☐ Chief Residency
☒ Fellowship
☐ Research
Specialty/Subspecialty: Family Planning
From: 07/01/2006 To: 06/30/2008
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☒ None

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

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

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

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

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

Please explain any "Yes" response from above:

____

____

Certification:

ELECTRONIC SEAL VERIFIED

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

Name: Lisa L. Harris, MD, PhD
Signature: [redacted]
Title: Program Director
Date of Signature: 10/[redacted]/06
Tel: 734-615-3773 Fax: 734-764-7281 E-Mail: nancydur@med.umich.edu

Federation of STATE MEDICAL BOARDS

Full Name: Willie James Parker
Packet #: 91393

University of Michigan Medical School
Complete name of hospital where training was conducted (Do not abbreviate).

Complete name of affiliated university or college (Do not abbreviate).

PROVIDED BY APPLICANT

Department of Obstetrics and Gynecology
Address line 1
1500 East Medical Center Drive, F4808 Mott
Address line 2

Ann Arbor — City
MI — State/Province
USA — Country
48109 - 0276 — ZIP/Postal Code

20. Postgraduate Medical Education

List all of the postgraduate medical education programs you attended in chronological order. **Use one page per institution.**

IMPORTANT:

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

If your postgraduate year is currently in progress, indicate the EXPECTED completion date in the "To" field.

Report internships, residencies, fellowships and research programs separately.

Use one section per department.

(PGY) – Postgraduate years is also known as postgraduate training level.

If a break of six (6) months or more occurred between any of your postgraduate training activities, please provide a written explanation outlining your activities during this period on the "Explanation of Other Activities" form.

PGY: 5
- [ ] Internship
- [ ] Residency
- [ ] Chief Residency
- [X] Fellowship
- [ ] Research

Family Planning
Specialty/Subspecialty
From: 07/2006 To: 06/2008
Successfully Completed? [X] Yes [ ] No [ ] In Progress

PGY: ____
- [ ] Internship
- [ ] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

Specialty/Subspecialty
From: ___/___ To: ___/___
Successfully Completed? [ ] Yes [ ] No [ ] In Progress

PGY: ____
- [ ] Internship
- [ ] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

Specialty/Subspecialty
From: ___/___ To: ___/___
Successfully Completed? [ ] Yes [ ] No [ ] In Progress

PGY: ____
- [ ] Internship
- [ ] Residency
- [ ] Chief Residency
- [ ] Fellowship
- [ ] Research

Specialty/Subspecialty
From: ___/___ To: ___/___
Successfully Completed? [ ] Yes [ ] No [ ] In Progress

Unusual Circumstances (check yes or no):

Question	Yes	No
Did you ever take a leave(s) of absence or break(s) from your medical education?	[ ]	[X]
Were you ever placed on probation?	[ ]	[X]
Were you ever disciplined or placed under investigation?	[ ]	[X]
Were any negative reports for behavioral reasons ever filed against you?	[ ]	[X]
Were any limitations or special requirements imposed on you because of academic, incompetence, disciplinary problems or for any other reason?	[ ]	[X]

Please explain any "YES" response from above:

Signature: *Willie J. Parker* Date: 6/29/2009

By typing my name above, I certify that I am the individual referenced in the FCVS application and that I agree to the terms and conditions set forth therein. Furthermore, I acknowledge that I have answered all questions and reported all information on this application page truthfully and completely.

Section V

Examination History/Score Transcripts

STATE MEDICAL BOARDS

FE[illegible]RATION LICENSING E[illegible]AM[illegible]ATIO[illegible](FLE[illegible])
Certified Transcri[illegible] of Scores

This Transcript was prepared by the Federation of State Medical Boards

Federation Credentials Verification Service
ATTN: FCVS2
Euless, TX 76039

Packet ID: 91393

EXAMINEE: Parker, Willie James
USMLE ID#: 2-216-479-2
DOB: [illegible]1962
ALTERNATE NAME(S):

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

FIN: 621018005 **Date of Certification: 10/20/2011**

Date of Exam	State Exam Taken For	State ID	Comp 1	Comp 2
6/12/90	IOWA	10134	80	80

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

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

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

ALABAMA BOARD OF MEDICAL EXAMINERS

P.O. Box 946 — Montgomery, AL 36101
848 Washington Avenue - 36104
(334) 242-4116

$175
rec'd

APPLICATION FOR CERTIFICATE TO PRACTICE MEDICINE THROUGH ENDORSEMENT

To The Board of Medical Examiners of the State of Alabama:

I hereby make application for a certificate to practice medicine and surgery in the State of Alabama, and submit the following statement concerning my age, moral character, preliminary and medical education and practice.

1. Name in Full Willie James Parker (M.D.) D.O. (Choose One)
   (First) (Middle) (Last)
2. Address (Street)
3. Place of Birth Birmingham, AL (City) Date of Birth L, /62 Email: f
   Social Security # (Sex) M Telephone (H) 808-271-0260 (W) 808-271-0260
   Washington DC 20017

		YES	NO
4	Indicate whether you are a citizen of the U.S. If yes, and foreign born, attach proof of citizenship If no, indicate your status with U.S immigration and attach a copy of your current Visa or Work Permit.	X	
5.	Have you ever been convicted of a felony? (If yes, please provide the name of the court of record or a copy of the record of conviction.)		X
6.	Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine? (If yes, please provide the name of the court of record or a copy of the record of conviction.)		X
7.	Have you ever been convicted of any violation of a state or federal law relating to controlled substances? (If yes, please provide the name of the court of record or a copy of the record of conviction.)		X
8.	Have you ever been denied a state or federal controlled substance certificate?		X
9.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered under threat of suspension or revocation?		X
10.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?		X
11.	Have you ever been denied a certificate of qualification or a license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial?		X
12.	Have you ever had a judgement rendered against you, or action settled relating to performance of your professional service?		X
13.	To your knowledge, are you the subject of an investigation by any licensing Board/Agency as of the date of this application?		X
14.	Within the past two years, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder?		X
15.	Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect your ability to practice in a competent and professional manner?		X
16.	Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution; employer; government agency, professional organization or licensing authority?		X
17.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?		X
18	Are you currently engaged in the illegal use of controlled dangerous substances?		X
19	If you answer to the preceding question is yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?		N/A
20.	Have you been within the past five years, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?		X
21.	Has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation?		X
22.	Have you ever been placed on academic or disciplinary probation by a medical school or postgraduate program?		X
23.	Have you ever been disciplined for unprofessional conduct/behavior reasons by a medical school or postgraduate program?		X
24	Were you notified in writing that there were limitations or special requirements imposed on you because of questions of academic or clinical incompetence, disciplinary problems or any other reason during your medical education or postgraduate training?		X

"The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the condition referred to may have an ongoing impact on one's functioning as a physician within the past two years.

IF ANY OF THE ABOVE ANSWERS ARE IN THE AFFIRMATIVE, PLEASE EXPLAIN IN DETAIL ON AN ATTACHED SHEET AND PROVIDE THE COMPLETE ADDRESS OF ANY PSYCHIATRIST/PSYCHOLOGIST, STATE BOARD, HOSPITAL, ETC.

25. Military Service, Branch n/A Dates

26. Place of Intended Residence in Alabama Birmingham

I. PRELIMINARY AND PRE-MEDICAL EDUCATION

List all schools attended, elementary through college and post-graduate work other than medical school.

	Name of School	Dates Attended	Degree Conferred
1.	Woodward Elementary	1969-70	none
2.	Dolemite Elementary	1970-71	none
3.	Wylam Elementary School	1971-77	none
4.	Ensley High School	1977-81	High School Diploma
5.	Berea College, Berea KY	1981-86	B.A. Biology/Liberal Arts
6.	Harvard University	Summer 1984	no degree
7.			

II. MEDICAL EDUCATION

0 16 0 30

List all medical schools attended, dates, and complete addresses of institutions. Do not list post graduate medical education training.

	Name of School	Address
1. From 6/86 to 5/90	Univ of Iowa	CMAB Iowa City IA. One Jessup Hall Iowa City IA 52242
2. From ____ to ____		
3. From ____ to ____		

III. POST GRADUATE MEDICAL EDUCATION TRAINING

List all post graduate medical education training since graduation from medical school with dates and complete addresses of institutions. Do not list practice experience.

	Hospital/Institution	Address
1. From 7/90 to 6/94	Univ of Cincinnati	PO Box 670526 · 231 A. Sabin Way Cincinnati, OH 45267-0526
2. From 7/00 to 6/01	UC. San Francisco	UCSF Dept. Occupational Medicine PO Box 0843 San Francisco, CA 94143
3. From 7/06 to 6/08	Univ. of Michigan	Dept - OB-Gyn F 4308 Mott 1500 East Medical Ctr Drive Ann Arbor MI 48109
4. From ____ to ____		
5. From ____ to ____		
6. From ____ to ____		
7. From ____ to ____		
8. From ____ to ____		

Specialty(s) OB-Gyn

IV. ORIGINAL LICENSE
(If Applicable)

I was issued my original (first) license in the State of Iowa on 3/19/92
license number 2.8574 based upon Flex examination examination I certify that this license has not been the subject of any disciplinary action. If so please explain on attached sheet.

V. ACTIVITIES FOLLOWING MEDICAL SCHOOL AND TRAINING

List all practice experience since completion of your formal training giving dates, institutions/hospitals, and complete address. Use separate sheet if necessary.

	Place	Address
1. From 7/94 to 6/97	Golden Valley Health Ctr	847 W. Childs Avenue Merced CA 95341
2. From 7/97 to 6/98	Harvard School Public Health	677 Huntington Ave Kresge 6th Boston, MA 02115
3. From 7/98 to 6/2000	Centers for Disease Control	EIS Program, CDC 1600 Clifton Road, Atlanta GA 30333
4. From 7/2000 to 8/2001	UCSF Div Prev. Med.	UCSF, Div. Prev. Medicine & Public Health San Francisco CA 94105
5. From 5/2001 to 12/2001	CA Dept Health Svcs	~~700 ... SF~~ PO Box 997413 Sacramento CA 95899
6 From 12/2001 to 1/2002	Vacation	
7. From 1/2002 to 5/2006	Queens Med. Ctr	1301 Punchbowl Street, Honolulu HI 96813
8. From 6/2006 to 7/2006	Vacation	
9. From 7/2006 to 6/2008	Univ Mich Med Ctr	1500 E. Med Ctr Drive Ann Arbor MI 48109
10. From ____ to ____		

VI. HOSPITAL PRIVILEGES

List all hospitals where you have held staff privileges of any type. Attach sheet if necessary.

	Hospital	Address
1. From 7/92 to 6/94	Mercy Anderson	7500 State Road Cincinnati OH 95255
2. From 7/94 to 6/97	Mereed Comm Med Ctr	2740 M Street Merced CA 95340
3. From 7/95 to 6/97	Mercy Hospital	2740 M Street Merced CA 95340
4. From 1/2002 to 5/2006	Queens Med. Ctr	1301 Punchbowl street Honolulu HI 96813
5. From 5/2003 to 6/2006	Kapiolan. Med Ctr	1319 Punahou Street 96826
6. From 6/2006 to 6/2008	Univ Michigan Med Ctr	1500 E. Med Ctr Drive Ann Arbor MI 48109
7. From ____ to ____	~~Queens Med Ctr~~	
8. From 8/2008 to present	Washington Hospital Cen	100 Irving Street Wash DC 20010
9. From ____ to ____		
10. From ____ to ____		
11. From ____ to ____		
12. From ____ to ____		
13. From ____ to ____		
14. From ____ to ____		

VII. STATE LICENSURE
(If Applicable)

List all states where you have been licensed to practice medicine or have applied for a license to practice medicine. It is a requirement that each state complete one of the verification forms which will be attached to your application

CA	VA	OH
IA	PA	
HI	MD	
DC	MI	

VIII. SPECIALTY BOARD CERTIFICATION

Are you CURRENTLY certified by one of the specialty boards approved by the American Board of Medical Specialties or the American Osteophathic Association? YES X NO ____

(If your answer is YES you must have your Specialty Board send verification directly to this office.)

IX. SPEX

1. Have you successfully completed a written licensing examination within the last ten years? YES ____ NO X
2. Have you been certified or re-certified by one of the specialty boards approved by the American Board of Medical Specialties or the American Osteopathic Association? YES X NO ____

X. AFFIDAVIT AND RELEASE

I, Willie James Parker, certify after being duly sworn, that all of the information supplied in the foregoing application is true and correct to the best of my knowledge, that the photograph submitted is a true likeness of myself and was taken within sixty days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation of my license to practice medicine granted to me and criminal prosecution to the fullest extent of the law.

I further authorize the release of this application and any information submitted with it or information collected by the Alabama Board of Medical Examiners in connection with this application, including derogatory information, to any person or organization having a legitimate need for the information and release the Alabama Board of Medical Examiners from all liability for the release of this information.

I further authorize the release of information, including derogatory information, which may be in the possession of other individuals or organizations to the Alabama Board of Medical Examiners and release this person or any organization from any liability for the release of information.

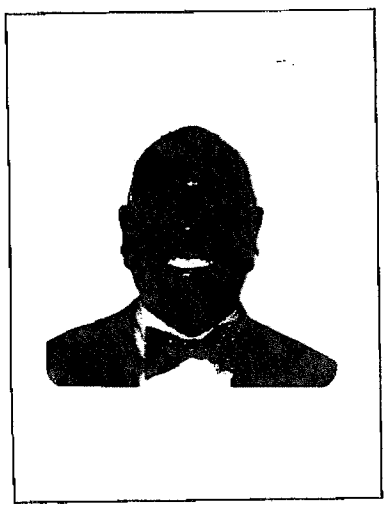
Date 11/28/11

Applicant's Signature

County of ____

State of District of Columbia

SWORN to and subscribed before me this 28th day of November, 20 11.



Notary Public

My Commission Expires Chang Ho Choi Notary Public District of Columbia My Commission Expires 6/14/14

THE ALBME WILL ENFORCE THE BOARD'S RULES AND REGULATIONS FOR THE ISSUANCE OF NON-DISCIPLINARY ACTION AND ADMINISTRATIVE CHARGE WHEN AN APPLICANT FALSIFIES AN APPLICATION.

Parker

ALABAMA STATE BOARD OF MEDICAL EXAMINERS

JACKIE BASKIN, DIRECTOR OF LICENSURE

P.O. BOX 946
MONTGOMERY, ALABAMA 36101-0946

TELEPHONE: (334) 833-0165
or (334) 242-4116
FAX: (334) 240-3388
EMail: jbaskin@albme.org

December 9, 2011

Willie James Parker, M.D.
2819 5th Street, NE
Washington, DC 20017

Dear Dr. Parker:

This will acknowledge receipt of your Application for Certificate to Practice Medicine. You may **check the status of your application On Line by** following these steps:

1. Log onto www.albme.org
2. Click on the **CHECK PENDING APPLICATION** heading
3. Enter your last name and the last 4 digits of your social security number
4. Check Status

If you are using a credentialing service to help you with your application you must provide them with this information so they will also be able to check the status of your application. Due to the large number of applicants, **this office will no longer accept phone calls to check the status of an application**. The website is updated daily.

The Board of Medical Examiners meets once monthly. Your application must be completed (all supporting documents received) by the fourth Wednesday of the month to be considered by the Board at the next month's meeting. Once your application is complete, you will be notified by mail of the meeting date.

If you have any questions or have any problems accessing this site, please contact Mr. Carl Martin, IT Department, 334-242-4116.

Sincerely,

Jackie Baskin

~~CAC~~
~~C-I-A~~
~~FLEP~~
~~Bd. Cert.~~
~~Period: 9/08-11/11~~
~~CA, VA, DH, PA, HC, MD, DC, MT~~
~~only MD Cletter~~

ALABAMA STATE BOARD OF MEDICAL EXAMINERS

JACKIE BASKINDIRECTOR OF LICENSURE

P.O. BOX 946
MONTGOMERY, ALABAMA 36101-0946

TELEPHONE: (334) 833-0165
FAX: (334) 240-3388
E MAIL: jbaskin@albme.org

March 22, 2012

Willie James Parker, M.D.
2819 5th Street, NE
Washington, DC 20017

Dear Dr. Parker:

This will acknowledge receipt of your completed application for endorsement. Your application will be considered by the Board of Medical Examiners at its meeting on **April 12, 2012.**

If you are approved by the Board a certificate of qualification will be issued to the Medical Licensure Commission, the agency responsible for the issuance of your license to practice medicine/osteopathy in this state. Enclosed please find an application for licensing by the Commission. **In order to expedite your application, please complete the enclosed form and return to the Commission's office with the required fee of $75. This form and fee must be received prior to issuance of a license number**. The Commission will meet on **April 18, 2012.**

Also enclosed is an application for your Alabama Controlled Substances Certificate (ACSC). Complete the application, **to include your full name and correct address, and return it with the required fee of $150 payable to the Alabama State Board of Medical Examiners.** In Alabama you are required to possess an ACSC and a DEA Certificate if you dispense and/or prescribe controlled substances.

I am enclosing an information sheet which contains important information. If you have any questions, or if this office can be of further assistance to you please contact us.

Sincerely,

Jackie Baskin
Director of Licensure

/jb

Encs.