

IOWA STATE BOARD OF MEDICAL EXAMINERS

State Capitol Complex
Executive Hills West
Des Moines, Iowa 50319

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE AND SURGERY OR OSTEOPATHIC MEDICINE AND SURGERY ON THE BASIS OF INTER-STATE ENDORSEMENT, FLEX ENDORSEMENT OR ACCEPTANCE OF THE CERTIFICATION OF THE NATIONAL BOARD OF MEDICAL EXAMINERS OF THE UNITED STATES OF AMERICA, INC. OR THE NATIONAL BOARD OF EXAMINERS FOR OSTEOPATHIC PHYSICIANS AND SURGEONS, INC.

To: The Iowa State Board of Medical Examiners:
I hereby make application for a license to practice medicine and surgery or osteopathic medicine and surgery in the state of Iowa and submit for your consideration the following statements.

(NAME MUST COINCIDE WITH MEDICAL DIPLOMA)

Application Should be Typewritten

1. Name PARKER WILLIE JAMES
2. Address 143 Goethe Street Cincinnati, Ohio Hamilton 45210
3. Place of Birth Alabama Date of Birth October 18, 1962 Age 29
4. Name and address (Father) deceased
5. Name and address (Mother) deceased
6. Are you a citizen of the United States? Yes Give particulars native born
7. Identification: Height 5'10 1/2" Weight 195 Color of Hair black
Color of Eyes brown Identifying marks none

8. PRELIMINARY EDUCATION (Beginning with High School. Give names of institutions attended and location, with concise statement of periods of study.)
High School Ensley High School, Birmingham, Alabama 1977-1981
College Berea College, Berea, Kentucky 1981-1986
Academic Degree of B. Arts from Berea College on 05/25/86

9. MEDICAL EDUCATION
I have spent 4 years in the study of medicine, each year comprising 12 each, in the following institutions:
Freshman University of Iowa, Iowa City, IA from 06 19 86 to 05 19 87
Sophomore University of Iowa, Iowa City, IA from 08 19 87 to 06 19 88
Junior University of Iowa, Iowa City, IA from 07 19 88 to 06 19 89
Senior University of Iowa, Iowa City, IA from 07 19 89 to 05 19 90
I was granted the degree of Doctor of Medicine by University of Iowa College of Medicine located at Iowa City, Iowa, on the 4th day of May, 19 90

10. INTERNSHIP
I have served an internship in the following hospital: University of Cincinnati Hospital Cincinnati, Ohio from July 1 19 90 to June 30 19 91
(A photostatic copy of my internship certificate is submitted herewith.) University of Cincinnati Hospital does not issue certificate at the end of intern year

11. RESIDENCIES (Give places and dates of each service) I have served Residencies in the following hospitals:
University of Cincinnati Hospital Ob/Gyn from July 1 19 91 to present 19
I was certified by on
(Enclosed is a photostatic copy of certificate)

12. CERTIFICATION OF MEDICAL EDUCATION: (MUST BE COMPLETED BY MEDICAL SCHOOL)
It is hereby certified that Willie James Parker of Cincinnati, Ohio, was granted a diploma with the degree of Doctor of Medicine by the University of Iowa College of Medicine located at Iowa City, State of Iowa on the 4th day of May, 19 90, and that the attached photograph is a true likeness of applicant.

(SCHOOL SEAL)

James A. Clifton
Secretary or Dean of School
James A. Clifton, M.D., Interim Dean

13. STATES AND COUNTRIES IN WHICH YOU HAVE EVER BEEN LICENSED,  
(Including training or temporary licensure.)

(Exam, Nat. Brd, Endorsement)

State Ohio License No. 36111 Date 07/01/91 How Obtained temporary through Univ of Cincinnati Hospital  
State \_\_\_\_\_ License No. \_\_\_\_\_ Date \_\_\_\_\_ How Obtained \_\_\_\_\_  
State \_\_\_\_\_ License No. \_\_\_\_\_ Date \_\_\_\_\_ How Obtained \_\_\_\_\_  
State \_\_\_\_\_ License No. \_\_\_\_\_ Date \_\_\_\_\_ How Obtained \_\_\_\_\_

14. IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED 'YES', PROVIDE A FULL AND DETAILED EXPLANATION WITH THIS APPLICATION. (ATTACH ADDITIONAL PAGES AS REQUIRED.)

A. Chronological listing of the dates and cities in which you have practiced your profession, also a chronological listing of any hospitals, clinics or similar facilities in which you had staff privileges. Include ALL periods of time from date of graduation from medical/osteopathic school to the present, whether or not engaged in activities related to medicine.

University of Cincinnati Hospital, Cincinnati, OH July 1, 1990 - present

B. Location of intended practice or training? Ohio

C. What type of practice? obstetrics and gynecology

D. Have you ever been denied staff membership in any hospital? no

E. Have you ever been warned, censured by, or requested to withdraw from any hospital in which you have trained, been a staff member, or held hospital privileges? no

F. Have you ever been notified, or requested to appear before any medical/osteopathic society or association in regard to charges filed against you? no Have you ever been rejected by a medical/osteopathic society or association? \_\_\_\_\_

G. Have you ever failed to pass any state medical/osteopathic licensing agency examination, National Board or FLEX examination? no If so, where and how many times? \_\_\_\_\_

H. Have you ever been denied a certificate by, or the privilege of taking an examination before any state medical/osteopathic licensing agency? no

I. Have you ever been under investigation by the medical/osteopathic licensing agency of any state in which you are or have been licensed to practice? no If yes, provide details. \_\_\_\_\_

J. Have you ever been notified by, or requested to appear before any state medical/osteopathic licensing agency in regard to charges or complaints filed against you, or as part of any investigation being conducted in which you are a party? no

K. Has any state medical/osteopathic licensing agency suspended or revoked a license it granted you? no

L. Has disciplinary action of any type ever been taken against you by a state medical/osteopathic licensing agency? no

M. Have you ever voluntarily surrendered a license to practice medicine and surgery, osteopathic medicine and surgery or osteopathy? no If yes, was a license disciplinary action pending against you, or were you under investigation by a medical licensing agency, at the time the voluntary surrender of license was tendered? no

N. Are you now or have you ever been addicted to, abused, or excessively used alcohol, barbiturates, narcotics, habit-forming drugs or mood altering drugs? no

O. Are you now or have you ever been emotionally or mentally ill? no Have you ever received psychotherapy? no Have you ever been a patient (voluntarily or otherwise) in any institution for the treatment of mental illness, drug addiction or abuse, or alcohol problems? no

P. Have you ever been charged with a felony? no A misdemeanor? no If so, what was the disposition of the charges? \_\_\_\_\_

Q. Have you ever had a professional liability claim made against you, either personally or with your medical malpractice insurance carrier, which did not result in the filing of a malpractice or professional liability suit? no If so, was any settlement made to resolve the claim? \_\_\_\_\_

R. Have you ever been sanctioned in connection with the care and/or treatment provided to medicaid or medicare patients? no If yes, provide details. \_\_\_\_\_

S. Please disclose and detail all other matters which may bear on your ability to practice medicine.

T. Have you ever been sued for malpractice? no

U. Do you understand that if the license asked for is granted by this Board, it will be on the truth of the statements contained herein, which if false, will subject you to criminal prosecution and revocation of the said license certificate? yes

15. RECOMMENDATION OF SECRETARY OF LOCAL, COUNTY MEDICAL OR OSTEOPATHIC SOCIETY OR ASSOCIATION. If you are not a member of a county medical society, this affidavit must be signed by the Chief of Staff of the Hospital in which you are practicing or the head of the Department in which you are receiving hospital training.

I, Robert W. Rebar, M.D., Director  
(Secretary, Chief of Staff, Department Head)  
of Department of Obstetrics & Gynecology, University of Cincinnati  
(Medical/Osteopathic Society/Association or Hospital & Department)  
certify that Dr. Willie Parker of Cincinnati, Ohio is

known to me to be an ethical practitioner and is of good moral and professional character; I further certify that he/she is engaged in the reputable practice of medicine and surgery or osteopathic medicine and surgery in the State of Ohio.

I have carefully examined the statements made by the applicant and believe them to be true in every respect. I also state that the photograph attached is a recent and true likeness of said doctor.

Date 12/19/91 Signed Robert W. Rebar  
Title Professor and Director

Do Not Complete This Section: If application is based on acceptance of National Board Certificate, request the National Board send certification of scores directly to this office. If application is based on passing the FLEX, but you are not licensed in the state in which you passed the FLEX, request certification of scores sent directly from that examining board and also from the Federation of State Medical Boards of the U.S., Inc.

16. THE SECRETARY OR DIRECTOR OF THE STATE BOARD OF MEDICAL/OSTEOPATHIC LICENSING AGENCY ISSUING YOUR ORIGINAL LICENSE ON THE BASIS OF PASSING A WRITTEN EXAMINATION ADMINISTERED BY THE AGENCY SHOULD CERTIFY THIS SECTION.

(Applicant must have attached his/her photograph before Certification.)

I, \_\_\_\_\_, \_\_\_\_\_ of the \_\_\_\_\_  
Title  
State Medical/Osteopathic Licensing Agency, certify that Dr. \_\_\_\_\_ was granted Certificate/License No. \_\_\_\_\_  
on the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_, based on \_\_\_\_\_  
Written Examination  
administered by this agency on \_\_\_\_\_  
Medical/Osteopathic School of Graduation \_\_\_\_\_  
\_\_\_\_\_, Date \_\_\_\_\_  
School Location \_\_\_\_\_

I further certify that Dr. \_\_\_\_\_ in his/her written examination before this Licensing Agency obtained a General Average of \_\_\_\_\_ percent, or FLEX Weighted Average of \_\_\_\_\_ per cent in one sitting in the subjects as follows:

Anatomy \_\_\_\_\_, Physiology \_\_\_\_\_, Biochemistry \_\_\_\_\_, Pathology \_\_\_\_\_,  
Microbiology \_\_\_\_\_, Pharmacology \_\_\_\_\_, Behavioral Science \_\_\_\_\_.

BASIC SCIENCE AVERAGE \_\_\_\_\_

Medicine \_\_\_\_\_, Surgery \_\_\_\_\_, OB/GYN \_\_\_\_\_, Public Health \_\_\_\_\_,  
Pediatrics \_\_\_\_\_, Psychiatry \_\_\_\_\_.

CLINICAL SCIENCE AVERAGE \_\_\_\_\_

CLINICAL COMPETENCE AVERAGE \_\_\_\_\_

FLEX EXAMINATION TAKEN SUBSEQUENT TO JANUARY, 1985.

Component I \_\_\_\_\_ Component II \_\_\_\_\_

Acting on behalf of this state licensing agency, I certify the attached photograph is a true likeness of the applicant, and that the license or certificate referred to above has never been suspended or revoked, or limited. If disciplinary action has been authorized or is pending, please advise.

I, \_\_\_\_\_ being duly sworn according to law, depose and say that all statements and information contained above are true and complete to the best of my knowledge and belief.

Signature \_\_\_\_\_  
Title \_\_\_\_\_  
Date \_\_\_\_\_  
Licensing Agency \_\_\_\_\_

(SEAL)

IT IS THE PHYSICIAN'S RESPONSIBILITY TO NOTIFY THIS OFFICE OF ANY CHANGE OF ADDRESS TO INSURE THE TIMELY RECEIPT OF INFORMATION ESPECIALLY LICENSE RENEWAL APPLICATIONS.

APPLICANT MUST COMPLETE ONLY THE AFFIDAVIT IN THIS SECTION

License No. 28574  
 Book No. 6 Page No. 1695  
 License Issued March 19, 19 93

IOWA STATE BOARD OF MEDICAL EXAMINERS

National Board or Interstate Endorsement or FLEX Endorsement Application in Medicine and Surgery and

Osteopathic Medicine and Surgery

(License Mailed To The Following Address)

Name Willie James Parker, M.D.  
 Street 143 Goethe Street, #2

City Cincinnati  
 County Hamilton  
 State or Country Ohio Zip 45210

Date Fee Received \_\_\_\_\_, 19 \_\_\_\_\_

AFFIDAVIT OF APPLICANT:

State of OHIO  
 County of Hamilton

I, Willie J. Parker, being duly sworn state, under penalty of perjury, that the foregoing information contained in this application and any attachment is true and correct, and the attached photo is a true likeness of myself.

Sworn to before me on December 27, 19 91  
 Notary Public Deborah L. Berry  
 (Seal) of Ohio My Commission Expires Nov 11, 1996

APPLICANT MUST COMPLETE THIS SECTION

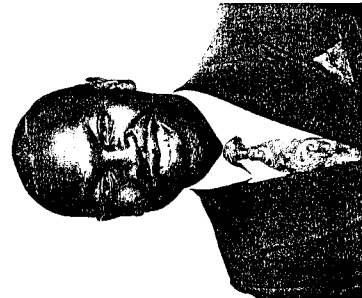
Name Willie J. Parker  
 Present Address 143 Goethe, #2  
Cincinnati, Ohio 45210  
 Age 29 Date and Place of Birth 10/18/62 Alabama  
 Name of College Issuing Diploma Berea College

Located at Berea, Kentucky (Under grad)  
University of Iowa College of Medicine  
 Date of Graduation May 26, 19 86

School of Practice University of Iowa  
Medicine/Osteopathic Medicine & Surgery

P.O. Address For License And Future Renewal Notices:  
 Street 143 Goethe Street, #2  
 City Cincinnati

State Ohio Zip 45210  
 County \_\_\_\_\_



INSTRUCTIONS

Application will not be accepted unless properly completed in every detail, signed and sworn to by the applicant, and properly notarized. Incomplete applications and credentials will be returned at the risk of the applicant.

Application must be accompanied by the following:

1. Fee of \$300.00 (Cashier's Checks or Money Orders). (APPLICATION FEES ARE NOT REFUNDABLE)
2. Notarized photo copies of all credentials listed (Copies no larger than 8x10 or smaller than 6x8)
  - a. Diploma from Medical/Osteopathic college.
  - b. Certificate of one year of postgraduate training in a hospital approved by the Board.
  - c. Copy of original state license by examination; or provincial license and LMCC Scores.
  - d. If National Board Diplomate, request National Board send certification of scores directly to this office.
  - e. If passed the FLEX, but not licensed in the state in which FLEX was passed, request certification of scores be sent directly to this office from the Federation of State Medical Boards of the U.S., Inc. also a letter from the state examining board verifying FLEX examination dates and what further requirements are necessary for your licensure.
  - f. FOREIGN MEDICAL GRADUATES must present notarized copy of a current standard certificate issued by the Educational Commission for Foreign Medical Graduates or notarized evidence of completion of an approved Fifth Pathway Program.

Foreign credentials must be accompanied by the English translation.

Foreign Medical Graduates may write for information concerning the standard certificate issued by the Educational Commission for Foreign Medical Graduates, 3624 Market Street, Philadelphia, PA 19104.

Address all correspondence to:

IOWA STATE BOARD OF MEDICAL EXAMINERS  
 State Capitol Complex  
 Executive Hills West  
 1209 East Court Avenue  
 Des Moines, Iowa 50319

IOWA STATE BOARD OF MEDICAL EXAMINERS  
State Capitol Complex  
Executive Hills West  
Des Moines, Iowa 50319

30 MAR 14 AM 11:45 525

To: The Iowa State Board of Medical Examiners:

I hereby make application to take the written examination for a license to practice medicine and surgery or osteopathic medicine and surgery in the State of Iowa and submit for your consideration the following statement.

IOWA STATE BOARD OF MED. EXAMINERS

(NAME MUST COINCIDE WITH MEDICAL DIPLOMA)

PLEASE USE TYPEWRITER

1. Name Willie James Parker Bus: \_\_\_\_\_ Phone: Home: (319) 338-0599  
2. Address 2430 Muscatine Ave., Apt. 24, Johnson Co., Iowa City, IA 52245  
3. Place of Birth Birmingham, Alabama Date of Birth October 18 1962 Age 27  
4. Name and address (Father) deceased  
5. Name and address (Mother) deceased  
6. Are you a citizen of the United States? yes Give particulars \_\_\_\_\_  
7. Social Security Number \_\_\_\_\_  
8. Identification: Height 71 inches (5' 11") Weight 195 Color of Hair Black  
Color of Eyes Brown Identifying marks none

9. PRELIMINARY EDUCATION (Beginning with High School. Give names of institutions attended and location, with concise statement of periods of study.)  
High School Ensley High School, Birmingham, AL 8/77 to 6/81  
College Berea College, Berea, KY 8/81 to 5/86  
Academic Degree of B.A., Biology from Berea College on 5/26/86

10. MEDICAL EDUCATION

I have spent 2/2 years in the study of medicine, each year comprising 32/47 each, in the following institutions:  
(~~hours~~ weeks)

Freshman Univ. of Iowa College of Medicine, Iowa City from June 1986 to May 1987  
Sophomore same from August 1987 to May 1988  
Junior same from May 1988 to May 1989  
Senior same from May 1989 to May 1990

I was granted the degree of Doctor of Medicine by University of Iowa  
located at Iowa City, Iowa, on the 4th day of May, 1990

A photostatic copy of my diploma is submitted herewith. (Photostat must not be larger than 8x10 in. or smaller than 6x8 in.)

I further state that I am the identical person to whom this diploma was granted, that the same was procured in the regular course of instruction without fraud or misrepresentation and that the copy presented herewith is a true copy of the original diploma of said institution.

11. INTERNSHIP

I \_\_\_\_\_ serve \_\_\_\_\_ an internship in the following hospital: \_\_\_\_\_  
(will or have) (Location) (Name)  
\_\_\_\_\_ from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
(Location)

(A photostatic copy of my internship certificate is submitted herewith)

12. RESIDENCIES (Give places and dates of each service.) I have served Residencies in the following hospitals:

\_\_\_\_\_ from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
(Name) (Location) (Specialty)  
\_\_\_\_\_ from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
(Name) (Location) (Specialty)

I was certified by \_\_\_\_\_ on \_\_\_\_\_  
(Name of Specialty Board) (Date)

(Enclosed is a photostatic copy of certificate)

13. ANSWER ALL QUESTIONS. IF THE ANSWER TO ANY QUESTION IS YES AND NOT FULLY ANSWERED BELOW, GIVE DETAILS IN A NOTARIZED AFFIDAVIT ATTACHED TO THE APPLICATION.

- A. Name states and/or foreign countries in which you have practiced and length of time in each. none.
- B. Where do you intend to practice in this state? I do not know.  
What type of practice? I will pursue a career in OB/GYN.
- C. List hospital staff positions (Give address and dates of service.) none.
- D. Have you ever been denied Staff Privileges by any hospital? no.
- E. Have you ever been warned or censured by, or requested to withdraw from any hospital in which you have trained, been a staff member, or held hospital privileges? no.
- F. Are you a member of any medical society? If so, give particulars: no.
- G. Have you ever been notified or requested to appear before any Medical Society in regard to charges or complaints filed against you? no.  
Have you ever been rejected by a Medical Society? no.
- H. Have you ever failed to pass ANY State Medical or Osteopathic Board Examination, National Board or FLEX examination? no.  
If so, name of examination, place (city & state), date, and the score received for each examination taken.
- I. Have you ever been denied a license by, or the privilege of taking an examination before any State Medical Board? no. Have you ever been notified by, or requested to appear before any State Medical Board in regard to charges or complaints filed against you? no. Has any State Medical Board suspended or revoked a license it had granted you? no.
- J. Are you now or have you ever been addicted to or excessively used alcohol, narcotics, barbituates, or habit-forming drugs? no.
- K. Are you now or have you ever been emotionally or mentally ill? no. Have you ever received psychotherapy? no.  
Have you ever been a patient (voluntary or otherwise) in any institution for the treatment of mental or emotional illness, drug addiction, or alcohol problems? no. Have you ever been treated, but not hospitalized for mental or emotional illness, drug addiction, or alcohol problems? no.
- L. Have you ever been charged with a felony? no. A misdemeanor? no. If so, what was the disposition of the charges?
- M. Have you ever had a professional liability claim made against you, either personally or with your medical malpractice insurance carrier, which did not result in the filing of a malpractice or professional liability suit? no. If so, was any settlement made to resolve the claim?
- N. DO YOU UNDERSTAND THAT IF THE LICENSE ASKED FOR IS GRANTED BY THIS BOARD, IT WILL BE ON THE TRUTH OF THE STATEMENTS CONTAINED HEREIN, AND THE ATTACHED HERETO, WHICH IF FALSE, WILL SUBJECT YOU TO CRIMINAL PROSECUTION AND REVOCATION OF THE SAID LICENSE CERTIFICATE? yes.

14. AFFIDAVIT OF APPLICANT:

State of Iowa  
County of Johnson ss.

I, Willie James Parker, being duly sworn, state, under penalty of perjury, that the information contained in this application and any attachments are true and correct, and that the attached photograph is a true likeness of myself.

W Parker  
(Signature of Applicant)

Sworn to before me this 2<sup>nd</sup> day of MARCH  
19 90. Michael L Evans  
(Notary Public)

My Commission expires 13 MARCH 1991



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AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

I, Willie J. Parker, do hereby authorize a review of the full disclosure of all records concerning myself to any duly authorized agent of the Iowa State Board of Medical Examiners, whether the said records are of a public, private or confidential nature.

The intent of this authorization is to give my consent for full and complete disclosure of records of state, territorial, or national medical or osteopathic licensing agencies or boards, educational institutions; medical and psychiatric treatment and/or consultation, including hospitals, clinics, private practitioners, and the U.S. Veteran's Administration; employment and pre-employment records, including background reports, efficiency ratings, complaints or grievances filed by or against me and records of any actions either criminal or civil, in which I presently have, or have had involvement, including arrest and criminal history records. This release also includes information concerning hospital staff membership or privileging, internship and/or residency records as well as records of hospitals, clinics, private physicians offices, attorneys and insurance companies regarding professional liability or malpractice claims and/or lawsuits.

I understand that any information obtained by a personal history background investigation which is developed directly or indirectly, in whole or in part, upon this release authorization will be considered in determining my suitability for licensure as a Medical Practitioner in the State of Iowa. I also certify that any person(s) who may furnish such information concerning me shall not be held accountable for giving this information; and I do hereby release said person(s) from any and all liability which may be incurred as a result of furnishing such information. I further release the Iowa State Board of Medical Examiners from any and all liability which may be incurred as a result of collecting such information.

A photocopy of this release form will be valid as an original thereof, even though the said photocopy does not contain an original writing of my signature.

I have read and fully understand the contents of this "Authorization for Release of Personal Information".

W. J. Parker M.D.  
(Signature of Applicant)

11/25/91  
(Date)

WITNESS:

[Signature]  
(Date)  
12-17-91  
(Date)

(LICENSURE)

Send a copy of this form to all hospitals where you have trained or been on staff.

IOWA STATE BOARD OF MEDICAL EXAMINERS  
1209 E. COURT AVENUE  
DES MOINES, IA 50319-0180  
515/281-5171

PLEASE PUT HOSPITAL  
NAME ON THIS FORM  
BEFORE MAILING OUT

The Physicians Application  
depends upon the return of  
this document.

RECEIVED FEB 11 1992

DATE: February 3, 1992

TO:

From: Licensing Section - University of Cincinnati Hospital, Cincinnati, OH

The following physician has made application for medical licensure in Iowa. He/she states he/she has/had staff privileges at your hospital. Please complete the form below as soon as possible. Thank you for your continued cooperation.

\*\*\*\*\*

Name: Willie J. Parker, M.D.

1. Does he/she have full staff privileges in his/her specialty? Currently PGY2

2. Does he/she perform competently? yes If no, explain. Resident — OBSTETRICS / Gynecology

3. Has he/she been regularly re-appointed? yes  
If no, explain. \_\_\_\_\_

4. Have any restrictions ever been placed on his/her privileges beyond the original period of probation? NO

Remarks: \_\_\_\_\_

Date: 2/5/92

Name: Nancy J. Cossler, M.D. 

Title: Associate Director, Residency Training Program, University of Cincinnati, Department of Obstetrics and Gynecology





TERRY E. BRANSTAD, GOVERNOR

BOARD OF MEDICAL EXAMINERS  
WILLIAM S. VANDERPOOL, EXECUTIVE DIRECTOR

March 19, 1992

Willie James Parker, M.D.  
143 Goethe Street, #2  
Cincinnati, OH 45210

RE: Medicine and Surgery Licensure

Dear Doctor:

This is a letter of confirmation informing you that you have been issued license number 28574 with an effective date of March 19, 1992, authorizing you to practice medicine and surgery in the state of Iowa.

The "original license" will be mailed to the above address in approximately three weeks.

Please contact this office should you need further verification, or have a change of address.

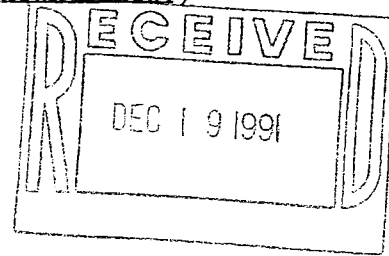
Sincerely,  
WILLIAM S. VANDERPOOL  
Executive Director  
Iowa State Board of Medical Examiners

BY: Judy Ireland  
License Secretary

NOTICE:

This license will expire on October 1, 1992.  
A renewal notice will be mailed to you  
60 days prior to the expiration date.  
Please be aware that the renewal fee  
must be paid immediately.

(Seal)



**DISCIPLINARY INQUIRIES**

Federation of State Medical Boards  
~~2600 West Freeway, Suite 138~~ 6000 Western Place, Suite 707  
Fort Worth, Texas ~~76102-7299~~ 76107

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

Willie James Parker  
Name

143 Goethe Apt. #2  
Address

Cincinnati OH 45210  
City, State and Zip

October 18<sup>th</sup> 1962  
Date of Birth

[REDACTED]  
Social Security Number

University of Iowa  
Medical School of Graduation and Branch Location

May 4, 1990  
Date of Graduation

DEC 20 1991

Please mail the response to the following address:

IOWA STATE BOARD OF MEDICAL EXAMINERS

STATE CAPITOL COMPLEX - EXECUTIVE HILLS WEST

1209 EAST COURT AVENUE

DES MOINES, IOWA 50319

WE HAVE NO UNFAVORABLE INFORMATION  
REGARDING THE ABOVE NAMED PHYSICIAN

ATTENTION:

LICENSING SECTION

DEC 30 1991

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

W Parker M D

PHYSICIAN SIGNATURE



## STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

January 8, 1992

Iowa State Board of Medical Examiners  
State Capitol Complex  
Executive Hills West  
Des Moines, Iowa 50310

To Whom It May Concern:

We are in receipt of your recent request for verification of the temporary certificate of Willie J. Parker.

Temporary certificates in Ohio are issued to physicians who have been appointed as interns, residents, or fellows in LCGME or AOA approved postgraduate training programs. Their practice is limited to the physical confines of the hospital, hospitals, or facilities for which the temporary certificate is granted and they must be under supervision of the attending staff. Temporary certificates are valid for the period of one year.

Although the Board is not in a position to verify expired temporary certificates, a review of our records indicates no formal disciplinary action has been taken against this doctor in Ohio.

If you have any questions concerning this matter, please contact me at the address above.

Sincerely,

Debra L. Jones, Chief  
C.M.E., Records & Renewal

DLJ:jdc

VERIFICATION OF LICENSURE

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

AUTHORIZATION FOR RELEASE OF INFORMATION

To Whom This May Concern:

In applying for a license to practice medicine and surgery or osteopathic medicine and surgery in the State of Iowa, the Iowa State Board of Medical Examiners requires this form be completed by each State Board in which I am now or have ever been licensed to practice my profession. My signature below is your authority to release any and all information in your files, favorable or otherwise regarding myself, directly to:

IOWA STATE BOARD OF MEDICAL EXAMINERS  
STATE CAPITOL COMPLEX  
EXECUTIVE HILLS WEST  
DES MOINES, IOWA 50319

W Parker MD  
(Applicant's Signature)

Name: Willie J. Parker

Address: 143 Goelke #2  
Cinti OH 45210

My License No. in Your State: 36111

DO NOT DETACH

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

State of: \_\_\_\_\_

Full Name of Licensee: \_\_\_\_\_

Graduate of: \_\_\_\_\_ Date of Degree: \_\_\_\_\_

License No.: \_\_\_\_\_ Issue Date: \_\_\_\_\_

By: Endorsement/Reciprocity with the following state \_\_\_\_\_

By: FLEX Endorsement \_\_\_\_\_ National Board \_\_\_\_\_ Your State Board's Written Examination \_\_\_\_\_

License is current? \_\_\_\_\_ If NO, Why Not? \_\_\_\_\_

Has license been suspended or revoked? \_\_\_\_\_ If YES, Why? \_\_\_\_\_

Has licentiate ever been on probation? \_\_\_\_\_ If YES, Why? \_\_\_\_\_

Has licentiate ever been requested to appear before your Board? \_\_\_\_\_ If YES, Why? \_\_\_\_\_

Is there any derogatory information? \_\_\_\_\_

Comments, if any \_\_\_\_\_

Signed: \_\_\_\_\_

Title: \_\_\_\_\_

State Board: \_\_\_\_\_

Date: \_\_\_\_\_

Board Seal

STATE MEDICAL BOARD  
OF IOWA  
92 JAN -7 AM 8:38

(Please Use Reverse Side For Additional Comments)

SOME STATE BOARDS REQUIRE AN ADMINISTRATIVE FEE PRIOR TO VERIFICATION

Rev. 10/11/85

TEMPORARY CERTIFICATE NO. 36111

Name PARKER, WILLIE J MD

Appointment RESIDENT

Specialty OBSTETRICS & GYNECOLOGY

Hospital UNIV OF CINTI HOSP/REN C

Effective dates of Issuance 07/01/91 TO 06/30/92

State of Ohio

County of Hamilton

This is a true copy of Willie J. Parker's current and temporary Ohio Medical License.

*Cheryl E. Treinen*

Notary Public

**CHERYL E. TREINEN**  
Notary Public, State of Ohio  
My Commission Expires Aug. 4, 1994

UNIVERSITY OF CINCINNATI  
HOSPITAL

University of Cincinnati  
Medical Center



College of Medicine

Department of Obstetrics and Gynecology

231 Bethesda Avenue (ML 526)  
Cincinnati, Ohio 45267-0526  
Phone (513) 558-8440  
FAX (513) 558-6138

March 13, 1992

Judy Ireland  
License Secretary  
State of Iowa  
Board of Medical Examiners  
1209 East Court, Executive Hills West  
Des Moines, IA 50319-0180

Dear Ms. Ireland:

This letter is to confirm that Dr. Willie Parker successfully completed one year of residency training (July 1, 1990 to June 30, 1991) in obstetrics and gynecology at the University of Cincinnati Hospital. Dr. Parker is currently a resident in good standing in the second postgraduate year. It is anticipated that he will complete residency training on June 30, 1994.

Sincerely,

A handwritten signature in cursive script, appearing to read "Rose Alden".

Rose Alden  
Residency Administrator

RECEIVED  
MARCH 19 1992  
UNIVERSITY OF CINCINNATI  
MEDICAL CENTER

# 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

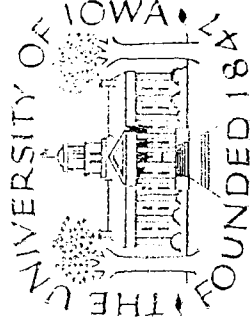
WHO HAS HONORABLY FULFILLED ALL THE REQUIREMENTS PRESCRIBED

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.

*Marion A. Sweeney*  
.....  
PRESIDENT OF THE STATE BOARD OF REGENTS



*Hunter R. Rawlings Jr.*  
.....  
PRESIDENT OF THE UNIVERSITY

*John Weckstein*  
.....  
DEAN OF THE COLLEGE

# The University of Iowa

Iowa City, Iowa 52242

College of Medicine  
Office of the Dean

319/335-8050  
FAX: 319/335-8049



1847

March 12, 1990

Mr. William S. Vanderpool  
Executive Director  
Iowa State Board of Medical Examiners  
State Capitol Complex  
Executive Hills West  
Des Moines, IA 50319

Dear Mr. Vanderpool:

This letter is to verify that Willie James Parker, currently a senior student in good standing in The University of Iowa College of Medicine, is expected to receive the degree Doctor of Medicine May 4, 1990. The photograph attached to the licensure application is a true likeness of this applicant.

Sincerely yours,

A handwritten signature in cursive script that reads "CM Helms".

Charles M. Helms, M.D., Ph.D.  
Associate Dean

CMH/lr