APP-SENT
4/13/92

STATE MEDICAL BOARD OF OHIO

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

REQUEST FOR APPLICATION FORMS
(MEDICAL OR OSTEOPATHIC LICENSURE)

PLEASE TYPE OR PRINT CLEARLY

I hereby submit the following information in order to receive an application for licensure:

NAME: PARKER (LAST/Surname) WILLIE (FIRST) JAMES (MIDDLE) (SUFFIX (Jr., II))

ADDRESS: 143 Goethe #2
STREET & NUMBER

Cincinnati (CITY) OH (STATE) 45210 (ZIP CODE) USA (COUNTRY)

TELEPHONE: BUSINESS: (513) 558-1000 (AREA CODE & NUMBER) HOME: (513) 651-9910 (AREA CODE & NUMBER)

BIRTH DATE: 10/18/62 (MO/DAY/YR) BIRTHPLACE: Birmingham (CITY) AL (STATE) USA (COUNTRY)

MEDICAL OR OSTEOPATHIC EDUCATION

MEDICAL SCHOOL OF GRADUATION: Univ of Iowa College of Medicine (SCHOOL NAME) CMAB (STREET ADDRESS)

Iowa City (CITY) IA (STATE) USA (COUNTRY)

6/18/86 (FROM: MO/DAY/YR) 5/14/90 (TO: MO/DAY/YR)

Doctor of Medicine (DEGREE RECEIVED) DATE RECEIVED: 5/14/90 (MO/DAY/YR)

OVER ⇨

OTHER MEDICAL SCHOOLS ATTENDED: (IF NONE, ENTER "NONE")

None
SCHOOL NAME

STREET ADDRESS CITY STATE COUNTRY

FROM: MO/DAY/YR TO: MO/DAY/YR

REASON DEGREE NOT RECEIVED AT THIS SCHOOL

SCHOOL NAME

STREET ADDRESS CITY STATE COUNTRY

FROM: MO/DAY/YR TO: MO/DAY/YR

REASON DEGREE NOT RECEIVED AT THIS SCHOOL

LICENSES IN OTHER COUNTRIES

LIST ALL FOREIGN COUNTRIES, EXCEPT CANADA, IN WHICH YOU HOLD OR HAVE HELD A FULL RIGHT TO PRACTICE MEDICINE AND SURGERY. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET. (IF NONE, ENTER "NONE")

COUNTRY none ISSUE DATE: _____ CURRENT: ☐ YES ☐ NO

COUNTRY _____ ISSUE DATE: _____ CURRENT: ☐ YES ☐ NO

FIFTH PATHWAY

FIFTH PATHWAY PROGRAM AT: (IF NONE, ENTER "NONE")

none
HOSPITAL OR INSTITUTION

AFFILIATED WITH: _____
NAME OF MEDICAL SCHOOL

ADDRESS: _____
STREET & NUMBER

_____
CITY STATE ZIP CODE

DATES ATTENDED: / / / /
FROM: MO/DAY/YR TO: MO/DAY/YR

QUALIFYING EXAM TAKEN: _____ DATE TAKEN: / /
MO/DAY/YR

GRADUATE MEDICAL EDUCATION

LIST ALL GRADUATE MEDICAL EDUCATION (INTERNSHIP, RESIDENCY, OR CLINICAL FELLOWSHIP), UNDERTAKEN IN THE U.S. OR CANADA. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET. (IF NONE, ENTER "NONE")

HOSPITAL: University of Cincinnati 234 Goodman Ave Cinti OH 45220
NAME STREET ADDRESS CITY STATE

POSITION: House Physician DEPARTMENT: OB/Gyn DATE: July /1990 present /
FROM: MO/YR TO MO/YR

HOSPITAL: ______
NAME STREET ADDRESS CITY STATE

POSITION: ______ DEPARTMENT: ______ DATE: ___/___ ___/___
FROM: MO/YR TO MO/YR

HOSPITAL: ______
NAME STREET ADDRESS CITY STATE

POSITION: ______ DEPARTMENT: ______ DATE: ___/___ ___/___
FROM: MO/YR TO MO/YR

HOSPITAL: ______
NAME STREET ADDRESS CITY STATE

POSITION: ______ DEPARTMENT: ______ DATE: ___/___ ___/___
FROM: MO/YR TO MO/YR

HOSPITAL: ______
NAME STREET ADDRESS CITY STATE

POSITION: ______ DEPARTMENT: ______ DATE: ___/___ ___/___
FROM: MO/YR TO MO/YR

WRITTEN EXAMINATIONS TAKEN

LIST EACH AND EVERY WRITTEN EXAM (OTHER THAN FLEX) WHICH YOU HAVE TAKEN WHETHER IN OHIO OR ANY OTHER STATE, TERRITORY OR PROVINCE. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET. (IF NONE, ENTER "NONE")

STATE: none DATE TAKEN: ______ ☐ PASS ☐ FAIL ☐ FULL ☐ PARTIAL

STATE: ______ DATE TAKEN: ______ ☐ PASS ☐ FAIL ☐ FULL ☐ PARTIAL

STATE: ______ DATE TAKEN: ______ ☐ PASS ☐ FAIL ☐ FULL ☐ PARTIAL

FLEX EXAMINATIONS TAKEN

LIST EACH AND EVERY FLEX EXAM WHICH YOU HAVE TAKEN WHETHER IN OHIO OR ANY OTHER STATE, TERRITORY OR PROVINCE. IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET. (IF NONE, ENTER "NONE")

STATE: Iowa DATE TAKEN: June 1990 ☑ PASS ☐ FAIL ☑ FULL ☐ PARTIAL

STATE: _____ DATE TAKEN: _____ ☐ PASS ☐ FAIL ☐ FULL ☐ PARTIAL

STATE: _____ DATE TAKEN: _____ ☐ PASS ☐ FAIL ☐ FULL ☐ PARTIAL

STATE: _____ DATE TAKEN: _____ ☐ PASS ☐ FAIL ☐ FULL ☐ PARTIAL

LICENSES IN THE UNITED STATES & CANADA

LIST ALL STATES/PROVINCES WHETHER THE LICENSE IS CURRENT OR NOT IN WHICH YOU ARE OR HAVE BEEN LICENSED TO PRACTICE MEDICINE AND SURGERY OR OSTEOPATHIC MEDICINE AND SURGERY. INDICATE THE LICENSE NUMBER, DATE OF ISSUANCE, AND THE BASIS OF LICENSURE (E.G., FLEX, STATE BOARD EXAM, ENDORSEMENT OF ANOTHER STATE LICENSE, ENDORSEMENT OF DIPLOMATE STATUS, ETC.) IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH AN EXTRA SHEET (IF NONE, ENTER "NONE").

STATE: Iowa ISSUE DATE: 3/19/92 LICENSE #: 28574

BASIS OF LICENSE: FLEX LICENSE CURRENT: ☑ YES ☐ NO

STATE: _____ ISSUE DATE: _____ LICENSE #: _____

BASIS OF LICENSE: _____ LICENSE CURRENT: ☐ YES ☐ NO

STATE: _____ ISSUE DATE: _____ LICENSE #: _____

BASIS OF LICENSE: _____ LICENSE CURRENT: ☐ YES ☐ NO

STATE: _____ ISSUE DATE: _____ LICENSE #: _____

BASIS OF LICENSE: _____ LICENSE CURRENT: ☐ YES ☐ NO

STATE: _____ ISSUE DATE: _____ LICENSE #: _____

BASIS OF LICENSE: _____ LICENSE CURRENT: ☐ YES ☐ NO

ADDITIONAL ELIGIBILITY INFORMATION - ANSWER ALL QUESTIONS

ARE YOU A DIPLOMATE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS?
❑ PENDING ❑ YES ☑ NO DATE: ____/____
MO/YR

ARE YOU A DIPLOMATE OF THE NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS?
❑ PENDING ❑ YES ☑ NO DATE: ____/____
MO/YR

ARE YOU A LICENTIATE OF THE MEDICAL COUNCIL OF CANADA? ❑ YES ☑ NO

ARE YOU APPLYING TO SIT FOR THE FLEX EXAM IN OHIO?
❑ YES ☑ NO IF YES, ❑ JUNE OR ❑ DECEMBER YEAR: 199___

ARE YOU SUBMITTING YOUR CREDENTIALS THROUGH THE AMERICAN MEDICAL ASSOCIATION NATIONAL PHYSICIAN CREDENTIALS VERIFICATION SERVICE? ❑ YES ☑ NO

DO YOU HAVE A VALID E.C.F.M.G. CERTIFICATE?
❑ YES ☑ NO NUMBER: _____ DATE ISSUED: ____/____
MO/YR

IF YOU ARE A GRADUATE OF A MEXICAN MEDICAL SCHOOL INDICATE DEGREE: (CHECK ONLY ONE)
❑ ACTA ❑ TITULO ❑ MEDICO CIRUJANO

HAVE YOU APPLIED FOR OR TAKEN THE TEST OF SPOKEN ENGLISH (T.S.E.)* OF THE EDUCATIONAL TESTING SERVICE? ❑ YES ☑ NO LAST DATE TAKEN OR SCHEDULED ____/____
MO/YR

HAVE YOU ACHIEVED A SCORE OF AT LEAST TWO HUNDRED THIRTY (230) ON THE TEST OF SPOKEN ENGLISH (T.S.E.)* OF THE EDUCATIONAL TESTING SERVICE? ❑ YES ☑ NO

* (THE T.O.E.F.L., E.C.F.M.G. EXAM, ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TEST OF SPOKEN ENGLISH (T.S.E.)

WERE YOU AN OHIO RESIDENT AT THE TIME OF ADMISSION TO MEDICAL SCHOOL?
❑ YES ☑ NO IF YES, GIVE FULL ADDRESS AT THAT TIME:

_____
STREET ADDRESS CITY STATE ZIP CODE

CERTIFICATION

I HEREBY CERTIFY THAT I AM THE PERSON REFERRED TO IN THE FOREGOING REQUEST FOR APPLICATION FORM AND THAT THE STATEMENTS THEREIN ARE STRICTLY TRUE IN EVERY RESPECT.

[signature] MD 4/6/92
SIGNATURE DATE

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 02/03/92

STATE MEDICAL BOARD OF OHIO

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

STATE MEDICAL BOARD OF OHIO
92 APR 24 AM 8:39

APPLICATION FOR CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE

ALL RESPONSES MUST BE TYPED

1. **SOCIAL SECURITY NUMBER** Redacted

2. **FULL NAME** (Use no initials)

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
PARKER	WILLIE	JAMES	

3. **NAME (As you prefer it inscribed on your Ohio license)**

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
PARKER	WILLIE	JAMES	

4. **MAIDEN NAME OR OTHER NAMES USED (If none, enter "NONE")**

LAST (Surname)	FIRST	MIDDLE	SUFFIX(Jr., II)
NONE			

5. **CURRENT ADDRESS**

STREET & NUMBER			
143 GOETHE STREET, APT. #2			
CITY	**STATE**	**ZIP CODE**	**COUNTRY**
CINCINNATI	OH	45210	USA

6. **PHYSICAL DESCRIPTION**

HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR	IDENTIFYING MARKS
5' 11"	195lbs	BLK	BROWN	NONE

7. **SEX** ☒ MALE ☐ FEMALE **For statistics only (optional)**

8. **CITY IN OHIO WHERE YOU PLAN TO PRACTICE**

CITY	OR	COUNTY
CINCINNATI		HAMILTON

PLANS OF PRACTICE: PRIVATE PRACTICE UPON COMPLETION OF TRAINING

9. **SPECIALTY BOARDS** (U.S.A., Canada and foreign countries)

Name of Specialty Board	Board Certified Yes	Board Certified No	Year Certified	Country
NONE	☐	☐		
	☐	☐		
	☐	☐		

FOR OFFICE USE ONLY 34 35 1-9 Examination Endorsement

33-35-81

4-27-92

185.00 #396

PAPERCLIP (DO NOT STAPLE) YOUR CHECK OR MONEY ORDER HERE

AW

32-35

PRELIMINARY EDUCATION FORM

NAME IN FULL IS: Parker Willie James
LAST (Surname) FIRST MIDDLE SUFFIX(Jr., II)

HIGH SCHOOL OR EQUIVALENT: Ensley High School B'ham AL USA
SCHOOL NAME CITY STATE COUNTRY
8 1 77 6 81
FROM: MO/YR TO: MO/YR

UNDERGRADUATE COLLEGE OR EQUIVALENT: Berea College Berea, KY KY USA
SCHOOL NAME CITY STATE COUNTRY
8 1 81 5 184 BA
FROM: MO/YR TO: MO/YR DEGREE
Harvard University Cambridge MA USA
SCHOOL NAME CITY. STATE COUNTRY
7 184 8 184 None
FROM: MO/YR TO: MO/YR DEGREE

MEDICAL OR OSTEOPATHIC SCHOOL OF GRADUATION: Univ of Iowa Iowa City IA USA
SCHOOL NAME CITY STATE COUNTRY
6 186 5 90 MD
FROM: MO/YR TO: MO/YR DEGREE

FOR BOARD USE ONLY

CERTIFICATE OF
PRELIMINARY EDUCATION

NO: 80525 DATE ISSUED: 5-15-92

This is to certify that this applicant has met the preliminary education requirements for study in conformity with the statutes of Ohio and the regulations of the State Medical Board of Ohio.

Ray L. Bumgarner
Entrance Examiner

Secretary

Revised 02/03/92

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

List ALL activities in chronological order from the date of medical school graduation to the present time using MONTH and YEAR. For any non-working time, you must state on the resume exactly what your activities were, such as "looking for residency program" or "vacation", as well as your permanent address for this period. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an "emergency medical group" or did locum tenens, you must list all hospitals where you worked and include complete dates and addresses. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, attach separate sheets.

Parker

A.

month/year	Hospital, University or Other:	Position & Department	% Clinical
07 90	University of Cincinnati Hospital	Resident Physician, Obstetrics and Gynecology	100
TO	Complete Street Address:		% Admin.
04 92	234 Goodman Street Street & Number		
	Cincinnati OH 45220 City State/Country Zip		

B.

month/year	Hospital, University or Other:	Position & Department	% Clinical
	Complete Street Address:		% Admin.
TO	Street & Number		
	City State/Country Zip		

STATE MEDICAL BOARD OF OHIO
92 APR 24 AM 8:39

C.

month/year	Hospital, University or Other:	Position & Department	% Clinical
	Complete Street Address:		% Admin.
TO	Street & Number		
	City State/Country Zip		

D.

month/year	Hospital, University or Other:	Position & Department	% Clinical
	Complete Street Address:		% Admin.
TO	Street & Number		
	City State/Country Zip		

E.

month/year	Hospital, University or Other:	Position & Department	% Clinical
TO	Complete Street Address:		% Admin.
month/year	Street & Number City State/Country Zip		

F.

month/year	Hospital, University or Other:	Position & Department	% Clinical
TO	Complete Street Address:		% Admin.
month/year	Street & Number City State/Country Zip		

G.

month/year	Hospital, University or Other:	Position & Department	% Clinical
TO	Complete Street Address:		% Admin.
month/year	Street & Number City State/Country Zip		

H.

month/year	Hospital, University or Other:	Position & Department	% Clinical
TO	Complete Street Address:		% Admin.
month/year	Street & Number City State/Country Zip		

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, YOU ARE REQUIRED TO FURNISH COMPLETE DETAILS, INCLUDING DATE, PLACE, REASON AND DISPOSITION OF THE MATTER. ALL AFFIRMATIVE ANSWERS MUST BE THOROUGHLY EXPLAINED ON A SEPARATE SHEET OF PAPER.

(Please place a ✔ in the yes or no box)

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☑
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☑
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☑
4.	Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, or graduate medical education?	☐	☑
5.	Have you ever transferred from one graduate medical education to another?	☐	☑
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☑
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☑

OVER ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

		YES	NO
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body, including those in Ohio?	☐	☑
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☑
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☑
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☑
12.	Have you ever been notified of any investigation concerning you by, or have you ever been notified of, any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
13.	Are you now or have you ever been, addicted to or excessively used alcohol, drugs, or other substances which may cause physical or psychological dependence, or impairment of the ability to practice?	☐	☑
14.	Have you ever been a patient (voluntary or otherwise) in any institution for the treatment of emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☑
15.	Have you ever been treated but not hospitalized for emotional or mental illness, drug addiction or abuse, or an alcohol problem? If yes, you must have your treating physician(s) submit a letter directly to the Board on your behalf summarizing dates of treatment, etc.	☐	☑
16.	Have you ever been denied, or surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☑

CONTINUED ⇨

ADDITIONAL INFORMATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE THREE

		YES	NO
17.	Have you ever been convicted or found guilty of a violation of federal law, state law, or municipal ordinance other than a minor traffic violation?	☐	☑
18.	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)?	☐	☑
19.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself?	☐	☑
20.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage cancelled, limited, or restricted in any way?	☐	☑
21.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☑
22.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☑

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must be sufficiently acquainted with the applicant for at least **SIX** months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, LAUREN DUNGY, a licensed and practicing physician in the state of
(recommending physician)

OHIO, affirm that Willie James Parker
(state of residence) (applicant)

has been known to me personally for 3 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for full licensure:

92 APR 24 AM 8:38

*I rate his/her medical knowledge and technique as: excellent

*His/her relationship with patients is: excellent

*I rate his/her ability to work well with peers and medical staff as: excellent

*His/her command of the English language is: excellent

*Additional comments: Very pleasant, competent individual

I hereby recommend him/her for full licensure to practice in the State of Ohio.

OVER ⇨

Lauren J. Dungy
Signature of Recommending Physician
(name stamps not acceptable)

LAUREN J. DUNGY
Name of Recommending Physician
(please type or print clearly)

(513) 558-8455
Telephone Number
(include area code)

University of Cincinnati
Address of Recommending Physician
(include city, state and zip code)

OHIO 35-05-8514
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

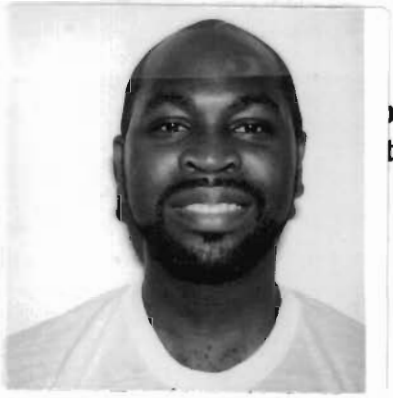
(NOTARY SEAL)

Subscribed and sworn to before me this 22nd day of April, 1992.

Cheryl E. Treinen
Notary Public Signature

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

Date Commission Expires



Parker MD
Signature of Applicant

Date Photo Taken: 4/92
Mo./Yr.

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

STATE MEDICAL BOARD OF OHIO

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MEDICINE OR OSTEOPATHIC MEDICINE

FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must be sufficiently acquainted with the applicant for at least **SIX** months. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. This form must be notarized. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to insure that certain information is included.

DO NOT COMPLETE UNLESS A *COLOR* PHOTO OF APPLICANT IS ATTACHED TO THE BACK OF THIS FORM

BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, ELBERT J. T. NELSON, M.D., a licensed and practicing physician in the state of
(recommending physician)

OHIO, affirm that DR. WILLIE J. PARKER
(state of residence) (applicant)

has been known to me personally for 3 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for full licensure:

*I rate his/her medical knowledge and technique as: SUPERIOR

*His/her relationship with patients is: EXCELLENT

*I rate his/her ability to work well with peers and medical staff as: SUPERIOR

*His/her command of the English language is: EXCELLENT

*Additional comments: THERE ARE NO PERSONAL OR MEDICAL PROBLEMS.

I hereby recommend him/her for full licensure to practice in the State of Ohio.

92 APR [illegible] 9:37 STATE MEDICAL BOARD OF OHIO

OVER ⇨

Signature of Recommending Physician
(name stamps not acceptable)

DR. ELBERT J. T. NELSON
Name of Recommending Physician
(please type or print clearly)

(513) 381-3700
Telephone Number
(include area code)

2340 AUBURN AVE #1
CINCINNATI, OH. 45219
Address of Recommending Physician
(include city, state and zip code)

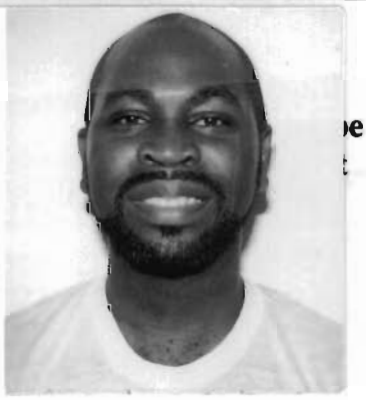
35-03-3005
State of Licensure & License Number of Recommending Physician
(please type or print clearly)

(NOTARY SEAL)

Subscribed and sworn to before me this 22nd day of April, 1992.

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

Date Commission Expires



Signature of Applicant

Date Photo Taken: 4/92
Mo./Yr.

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 2 - CERTIFICATE OF GRADUATE MEDICAL EDUCATION

MAIL TO HOSPITAL OR INSTITUTION OF GRADUATE MEDICAL EDUCATION IN THE U.S. OR CANADA

92 MAY 29 AM 11:36

Dear Sir:

I am applying for a license to practice in the State of Ohio. The State Medical Board of Ohio requires that my graduate medical education be certified. Please complete the form and return it directly to the State Medical Board of Ohio.

TO BE COMPLETED BY APPLICANT

Parker, Willie James — Name in full (last, first, middle, suffix)

10/18/62 — Date of birth (mo/day/yr)

143 Goethe Apt #2 Cinti OH 45210 — Complete address (street, city, state & zip)

University of Iowa — Medical school of graduation

I HEREBY AUTHORIZE MY HOSPITAL OR INSTITUTION OF GRADUATE MEDICAL EDUCATION TO FURNISH THE FOLLOWING INFORMATION TO THE STATE MEDICAL BOARD OF OHIO.

Parker MD — Signature of applicant

4/18/92 — Date

TO BE COMPLETED BY HOSPITAL OR TRAINING INSTITUTION

I offer the following in support of his/her application for full licensure:

I rate his/her medical knowledge and technique as: Good

His/her relationship with patients is: Good

I rate his/her ability to work well with peers and medical staff as: Good

His/her command of the English language is: Good

Additional comments: A hard working caring MD

OVER ⇨

FORM 2 - CERTIFICATE OF GRADUATE EDUCATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

This certifies that Willie J. Parker, MD (name of applicant) has rendered satisfactory and continuous

service as a(n): ☐ intern
☒ resident in OB-Gyn (department) at University Hospital (name of hospital)
☐ clinical fellow

234 Goodman Ave, Cincinnati (complete street address of hospital) from 07-01-9 (beginning mo/day/yr) to 06-30-94 (ending mo/day/yr).

It is further certified that the above named: ☒ will be awarded a certificate on} 06-30-94 mo/day/yr
☐ was awarded a certificate on} _____ mo/day/yr
☐ was not awarded a certificate
please explain: _____

and that the training: ☒ was accredited by ACGME/AOA
☐ was not accredited by ACGME/AOA

I hereby recommend him/her for full licensure to practice in the State of Ohio.

(SEAL OF HOSPITAL)*

*If hospital has no seal, please indicate and have form notarized.

Robert W Rebar
Signature of Medical Director or Program Director
(Original signature only, names stamps will not be accepted)

Robert W. Rebar MD
Name (please print or type)

4-22-92
Date

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

Revised 02/03/92

STATE MEDICAL BOARD OF OHIO

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

MEDICINE OR OSTEOPATHIC MEDICINE

FORM 3 - CERTIFICATE OF STATE BOARD

I am applying for a license to practice in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by the state in which I am licensed by examination, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio.

TO BE COMPLETED BY APPLICANT

Parker Willie J	28574	3/19/92
Name in full (last, first, middle, suffix)	License number	Issue date (mo/day/yr)
143 Goethe Apt #2 Cinti OH 45210	10/18/62	Univ of Iowa
Complete address (street, city, state & zip)	Date of birth	Medical school of graduation

I HEREBY AUTHORIZE THE LICENSING AGENCY OF THE STATE OR PROVINCE OF Iowa TO FURNISH THE INFORMATION BELOW TO THE STATE MEDICAL BOARD OF OHIO.

WP Parker MD	4/18/92
Signature of applicant	Date

TO BE COMPLETE BY STATE BOARD OR CANADIAN PROVINCE

Acting on behalf of Iowa Board (name of state board), I do hereby certify that Parker, Willie James (name of licensee: last, first, middle, suffix) was on the 19th day of March, 19 92, granted a license to practice: ☒ medicine ☐ osteopathic medicine in the State of Iowa (state of licensure) based on written examination of:

☒ FLEX Comp 1 - 80 Comp 2 - 80

☐ Endorsement from _____ (State or Province)

☐ Other (please specify)_____

☐ Written examination, other than the FLEX, prepared by this state or province.

OVER ⇨

FORM 3 - CERTIFICATE OF STATE BOARD - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

If based upon written state examination *prepared by this state or province,* I further certify that the aforesaid physician in his/her written examination before this Board on the_____day of_____, 19____ , obtained a general average of_____ in the following subjects:

SUBJECT/PERCENTAGE		SUBJECT/PERCENTAGE		SUBJECT/PERCENTAGE	
	%		%		%
	%		%		%
	%		%		%
	%		%		%
	%		%		%

Is License current: ☒ Yes ☐ No If not, please explain:_____

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?
☐ YES ☒ NO ☐ CANNOT ANSWER UNDER CURRENT STATE LAW **If yes, please attach complete details.**

Have formal disciplinary proceedings been initiated against applicant or applicant's license by a disciplinary authority in your state?
☐ YES ☒ NO ☐ CANNOT ANSWER UNDER CURRENT STATE LAW **If yes, please attach complete details.**

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?
☐ YES ☒ NO ☐ CANNOT ANSWER UNDER CURRENT STATE LAW **If yes, please attach complete details.**

NOTE: IF ANY PORTION OF THE ABOVE CERTIFICATION IS DELETED OR MODIFIED, PLEASE ATTACH AN EXPLANATION

Carolyn Mitchell
Signature of Secretary, President or Executive Secretary.

(AFFIX BOARD SEAL)
(NOT VALID WITHOUT SEAL)

Secretary
Title

May 1, 1992
Date

RETURN TO: STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR
COLUMBUS, OH 43266-0315

The Federation of State Medical Boards

of the United States

INCORPORATED

6000 WESTERN PLACE, SUITE 707

FORT WORTH, TEXAS 76107-4618

(817) 735-8445

To: Ohio State Medical Board.

Subject: Examination and Board Action History Report

WILLIE JAMES PARKER
143 GOETHE #2
CINCINNATI, OH
45210

It is certified that the above named physician took the Federation Licensing and/or Special Purpose 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: 05/08/92

DATE OF EXAM	STATE TAKEN FOR	STATE ID #	COMP 1	COMP 2
06/90	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 reponsibilities for the general health care of patients.

* *

Furthermore:

A search of the Federation's Board Action Data Bank reveals no reported disciplinary information on the above named physician.

kbb

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.

Hunter R. Rawlings III
PRESIDENT OF THE UNIVERSITY

John W. Eckstein
DEAN OF THE COLLEGE

Mavis A. Lawrence
PRESIDENT OF THE STATE BOARD OF REGENTS

[redacted]

AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release below MUST be completed by **ALL** applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered as incomplete.

ss STATE OF OHIO

COUNTY OF HAMILTON

I, WILLIE JAMES PARKER, hereby certify under oath that I am the person named in this application for a license to practice medicine or osteopathic medicine in the State of Ohio; 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 to this Board 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 respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is not refundable nor transferable.

I further state that by filing this application for a license to practice medicine or osteopathic medicine in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine or osteopathic medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that my application for a license to practice medicine or osteopathic medicine in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to licensure being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for licensure and that any fee I submitted is not refundable nor transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

I further understand that issuance of a certificate to practice medicine or osteopathic medicine in Ohio will be considered on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said certificate.

(NOTARY SEAL)

Willie Parker, M.D.
Signature of Applicant

STATE MEDICAL BOARD OF OHIO
92 APR 24 AM 8:39

Subscribed and sworn to before me this 20th day of April 1992.

Peggy J. Jones
Notary Public Signature

1/27/97
Date Commission Expires

Revised 02/03/92

FOR BOARD USE ONLY

NAME: Parker, Willie J.

CERTIFICATE NO.: 63458

DATE ISSUED: 5-29, 1992

APPLICATION FOR CERTIFICATE TO PRACTICE MEDICINE OR OSTEOPATHIC MEDICINE

FILED: April 10, 1992

FEE: _____

DETERMINATION:

BOARD ACTION:

AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 05/19/92

NAME: PARKER, WILLIE JAMES
SCHOOL: UNIV OF IOWA COL MED, IOWA CITY IA
DEGREE CONFERRED: MD
DATE CONFERRED: 05/04/90

INTERNSHIP

HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

RESIDENCY

HOSPITAL: UNIV OF CINCINNATI
CITY: CINCINNATI ST: OH
STARTING DATE: 07/90 ENDING DATE: 04/92
HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

FLEX EXAM

DATE OF EXAM: 06/90 STATE EXAM WAS TAKEN: IA

OLD FLEX

RS: % CS: %
CC: % FWA: %
BASIS: FLEX

NEW FLEX

COMPONENT_I: 080%
COMPONENT_II: 080%
BASIS_ST: IA

LETTERS OF RECOMMENDATION

NAME: LAUREN DUNGY, MD CITY: CINCINNATI STATE: OH
NAME: GILBERT NELSON, MD CITY: CINCINNATI STATE: OH

SPECIALITY CODE:
CODE:
CODE:

SPECIALITY BOARD:

	NOT IN	OK	N/A
AMA/AOA:		X	
TSE SCORE:			X
FED INFO:		X	
REC FORM:		X	
ECFMG:			X

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. AGRESTA, MD			
RAYMOND ALBERT			
ANAND G. GARG, MD			
THOMAS E. GRETTER, MD			
ROBERT S. HEIDT, MD			
THERESA M. HOM, DO			
TIMOTHY JOST			
RONALD J. KAPLANSKY, DPM			
CARLA S. O'DAY, MD			
CAROL ROLFES			
TIMOTHY L. STEPHENS, JR., MD			
CHARLES DENNY STIENECKER, MD	✓		

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

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Parker

	month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
A.	07 90 month/year TO 04 92 month/year	University of Cincinnati Hospital 234 Goodman Street Street & Number Cincinnati OH 45220 City State/Country Zip	Resident Physician, Obstetrics and Gynecology	100 /
B.	month/year TO month/year	Hospital, University or Other: Complete Street Address: Street & Number City State/Country Zip	Position & Department	% Clinical / % Admin.
C.	month/year TO month/year	Hospital, University or Other: Complete Street Address: Street & Number City State/Country Zip	Position & Department	% Clinical / % Admin.
D.	month/year TO month/year	Hospital, University or Other: Complete Street Address: Street & Number City State/Country Zip	Position & Department	% Clinical / % Admin.

AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 05/19/92

NAME: PARKER, WILLIE JAMES
SCHOOL: UNIV OF IOWA COL MED, IOWA CITY IA
DEGREE CONFERRED: MD
DATE CONFERRED: 05/04/90

INTERNSHIP

HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

RESIDENCY

HOSPITAL: UNIV OF CINCINNATI
CITY: CINCINNATI ST: OH
STARTING DATE: 07/90 ENDING DATE: 04/92
HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

FLEX EXAM

DATE OF EXAM: 06/90 STATE EXAM WAS TAKEN: IA

OLD FLEX

RS: % CS: %
CC: % FWA: %
BASIS: FLEX

NEW FLEX

COMPONENT_I: 080%
COMPONENT_II: 080%
BASIS_ST: IA

LETTERS OF RECOMMENDATION

NAME: LAUREN DUNGY, MD CITY: CINCINNATI STATE: OH
NAME: ELBERT NELSON, MD CITY: CINCINNATI STATE: OH

SPECIALITY CODE:
CODE:
CODE:

SPECIALITY BOARD:

	NOT IN	OK	N/A
AMA/AOA:		X	
FSE SCORE:			X
FED INFO:		X	
REC FORM:		X	
ECFMG:			X

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. ARGESTA, MD			
RAYMOND ALBERT			
ANAND G. GARG, MD			
THOMAS E. GRETTER, MD			
ROBERT S. HEIDT, MD			
THERESA M. HOM, DO	✓		
TIMOTHY JOST			
RONALD J. KAPLANSKY, DPM			
CARLA S. O'DAY, MD			
CAROL ROLFES			
TIMOTHY L. STEPHENS, JR., MD			
CHARLES DENNY STIENECKER, MD			

STATE MEDICAL BOARD OF OHIO
92 MAY 22 AM 10:05

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

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Parker

A.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
07 90	University of Cincinnati Hospital	Resident Physician, Obstetrics and Gynecology	100
TO	234 Goodman Street (Street & Number)		
04 92	Cincinnati OH 45220 (City / State/Country / Zip)		

B.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
TO	Street & Number		
	City / State/Country / Zip		

STATE MEDICAL BOARD OF OHIO
92 APR 2[illegible] AM 8:39

C.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
TO	Street & Number		
	City / State/Country / Zip		

D.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
TO	Street & Number		
	City / State/Country / Zip		

AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 05/19/92

NAME: PARKER, WILLIE JAMES
SCHOOL: UNIV OF IOWA COL MED, IOWA CITY IA
DEGREE CONFERRED: MD
DATE CONFERRED: 05/04/90

INTERNSHIP

HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

RESIDENCY

HOSPITAL: UNIV OF CINCINNATI
CITY: CINCINNATI ST: OH
STARTING DATE: 07/90 ENDING DATE: 04/92
HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

FLEX EXAM

DATE OF EXAM: 06/90 STATE EXAM WAS TAKEN: IA

OLD FLEX

BS: % CS: %
CC: % FWA: %
BASIS: FLEX

NEW FLEX

COMPONENT_I: 080%
COMPONENT_II: 080%
BASIS_ST: IA

LETTERS OF RECOMMENDATION

NAME: LAUREN DUNGY, MD CITY: CINCINNATI STATE: OH
NAME: GILBERT NELSON, MD CITY: CINCINNATI STATE: OH

SPECIALITY
CODE:
CODE:
CODE:

SPECIALITY
BOARD:

	NOT IN	OK	N/A
AMA/AOA:		X	
TSE SCORE:			X
FED INFO:		X	
REC FORM:		X	
ECFMG:			X

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. ARGESTA, MD			
RAYMOND ALBERT			
ANAND G. GARG, MD			
THOMAS E. GRETTER, MD			
ROBERT S. HEIDT, MD	✓		
THERESA M. HOM, DO			
TIMOTHY JOST			
RONALD J. KAPLANSKY, DPM			
CARLA S. O'DAY, MD			
CAROL ROLFES			
TIMOTHY L. STEPHENS, JR., MD			
CHARLES DENNY STIENECKER, MD			

STATE MEDICAL BOARD OF OHIO
92 MAY 22 AM 9:50

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

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TO	234 Goodman Street (Street & Number)		
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month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
TO	Street & Number		
	City / State/Country / Zip		

STATE MEDICAL BOARD OF OHIO
92 APR 27 AM 8:39

C.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
TO	Street & Number		
	City / State/Country / Zip		

D.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
TO	Street & Number		
	City / State/Country / Zip		

AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 05/19/92

NAME: PARKER, WILLIE JAMES
SCHOOL: UNIV OF IOWA COL MED, IOWA CITY IA
DEGREE CONFERRED: MD
DATE CONFERRED: 05/04/90

INTERNSHIP

HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

RESIDENCY

HOSPITAL: UNIV OF CINCINNATI
CITY: CINCINNATI ST: OH
STARTING DATE: 07/90 ENDING DATE: 04/92
HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

FLEX EXAM

DATE OF EXAM: 06/90 STATE EXAM WAS TAKEN: IA

OLD FLEX

BS: % CS: %
CC: % FMA: %
BASIS: FLEX

NEW FLEX

COMPONENT_I: 080%
COMPONENT_II: 080%
BASIS_ST: IA

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NAME: LAUREN DUNGY, MD CITY: CINCINNATI STATE: OH
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CODE:
CODE:

SPECIALITY BOARD:

	NOT IN	OK	N/A
AMA/AOA:		X	
TSE SCORE:			X
FED INFO:		X	
REC FORM:		X	
ECFMG:			X

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. AGRESTA, MD			
RAYMOND ALBERT			
ANAND G. GARG, MD			
THOMAS E. GRETTER, MD			
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CARLA S. O'DAY, MD			
CAROL ROLFES			
TIMOTHY L. STEPHENS, JR., MD			
CHARLES DENNY STIENECKER, MD			

92 MAY 22 AM 10:11
STATE MEDICAL BOARD OF OHIO

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

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A.	07 90 month/year TO 04 92 month/year	University of Cincinnati Hospital; 234 Goodman Street; Cincinnati OH 45220	Resident Physician, Obstetrics and Gynecology	100
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AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

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DEGREE CONFERRED: MD
DATE CONFERRED: 05/04/90

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STARTING DATE: / ENDING DATE: /

RESIDENCY

HOSPITAL: UNIV OF CINCINNATI
CITY: CINCINNATI ST: OH
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HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

FLEX EXAM

DATE OF EXAM: 06/90 STATE EXAM WAS TAKEN: IA

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CC: % FWA: %
BASIS: FLEX

NEW FLEX

COMPONENT_I: 080%
COMPONENT_II: 080%
BASIS_ST: IA

LETTERS OF RECOMMENDATION

NAME: LAUREN DUNGY, MD CITY: CINCINNATI STATE: OH
NAME: ELBERT NELSON, MD CITY: CINCINNATI STATE: OH

SPECIALITY CODE:
CODE:
CODE:

SPECIALITY BOARD:

	NOT IN	OK	N/A
AMA/AOA:		X	
TSE SCORE:			X
FED INFO:		X	
REC FORM:		X	
ECFMG:			X

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. AGRESTA, MD			
RAYMOND ALBERT			
ANAND G. GARG, MD			
THOMAS E. GRETTER, MD			
ROBERT S. HEIDT, MD			
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CARLA S. O'DAY, MD			
CAROL ROLFES			
TIMOTHY L. STEPHENS, JR., MD	✓		
CHARLES DENNY STIENECKER, MD			

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month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
TO	Street & Number		
	City / State/Country / Zip		

STATE MEDICAL BOARD OF OHIO
92 APR 27 AM 8:39

C.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
TO	Street & Number		
	City / State/Country / Zip		

D.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
TO	Street & Number		
	City / State/Country / Zip		

AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 05/19/92

NAME: PARKER, WILLIE JAMES
SCHOOL: UNIV OF IOWA COL MED, IOWA CITY IA
DEGREE CONFERRED: MD
DATE CONFERRED: 05/04/90

INTERNSHIP

HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

RESIDENCY

HOSPITAL: UNIV OF CINCINNATI
CITY: CINCINNATI ST: OH
STARTING DATE: 07/90 ENDING DATE: 04/92
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CITY: ST:
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CC: % FWA: %
BASIS: FLEX

NEW FLEX

COMPONENT_I: 080%
COMPONENT_II: 080%
BASIS_ST: IA

LETTERS OF RECOMMENDATION

NAME: LAUREN DUNGY, MD CITY: CINCINNATI STATE: OH
NAME: ELBERT NELSON, MD CITY: CINCINNATI STATE: OH

SPECIALITY CODE:
CODE:
CODE:

SPECIALITY BOARD:

	NOT IN	UK	N/A
AMA/AOA:		X	
TSE SCORE:			X
FED INFO:		X	
REC FORM:		X	
ECFMG:			X

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. ARGESTA, MD	✓		
RAYMOND ALBERT			
ANAND G. GARG, MD			
THOMAS E. GRETTER, MD			
ROBERT S. HEIDT, MD			
THERESA M. HOM, DO			
TIMOTHY JOST			
RONALD J. KAPLANSKY, DPM			
CARLA S. O'DAY, MD			
CAROL ROLFES			
TIMOTHY L. STEPHENS, JR., MD			
CHARLES DENNY STIENECKER, MD			

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

List ALL activities in chronological order from the date of medical school graduation to the present time using MONTH and YEAR. For any non-working time, you must state on the resume exactly what your activities were, such as "looking for residency program" or "vacation", as well as your permanent address for this period. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an "emergency medical group" or did locum tenens, you must list all hospitals where you worked and include complete dates and addresses. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, attach separate sheets.

Parker

A.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
07 90	University of Cincinnati Hospital	Resident Physician, Obstetrics and Gynecology	100
TO	234 Goodman Street (Street & Number)		
04 92	Cincinnati OH 45220 (City / State/Country / Zip)		

B.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
TO	Street & Number		
	City / State/Country / Zip		

STATE MEDICAL BOARD OF OHIO
92 APR 27 AM 8:39

C.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
TO	Street & Number		
	City / State/Country / Zip		

D.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
TO	Street & Number		
	City / State/Country / Zip		

AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 05/19/92

NAME: PARKER, WILLIE JAMES
SCHOOL: UNIV OF IOWA COL MED, IOWA CITY IA
DEGREE CONFERRED: MD
DATE CONFERRED: 05/04/90

INTERNSHIP

HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

RESIDENCY

HOSPITAL: UNIV OF CINCINNATI
CITY: CINCINNATI ST: OH
STARTING DATE: 07/90 ENDING DATE: 04/92
HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

FLEX EXAM

DATE OF EXAM: 06/90 STATE EXAM WAS TAKEN: IA

OLD FLEX

BS: % CS: %
CC: % FWA: %
BASIS: FLEX

NEW FLEX

COMPONENT_I: 090%
COMPONENT_II: 080%
BASIS_ST: IA

LETTERS OF RECOMMENDATION

NAME: LAUREN DUNGY, MD CITY: CINCINNATI STATE: OH
NAME: ELBERT NELSON, MD CITY: CINCINNATI STATE: OH

SPECIALITY CODE:
CODE:
CODE:

SPECIALITY BOARD:

	NOT IN	OK	N/A
AMA/AOA:		X	
TSE SCORE:			X
FED INFO:		X	
REC FORM:		X	
ECFMG:			X

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. ARRESTA, MD			
RAYMOND ALBERT			
ANAND G. GARG, MD			
THOMAS E. GRETTER, MD			
ROBERT S. HEIDT, MD			
THERESA M. HOM, DO			
TIMOTHY JOST			
RONALD J. KAPLANSKY, DPM			
CARLA S. O'DAY, MD			
CAROL ROLFES			
TIMOTHY L. STEPHENS, JR., MD			
CHARLES DENNY STIENECKER, MD			

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

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Parker

A.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
07 90	University of Cincinnati Hospital	Resident Physician, Obstetrics and Gynecology	100
TO	234 Goodman Street (Street & Number)		
04 92	Cincinnati OH 45220 (City / State/Country / Zip)		

B.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
TO	Street & Number		
	City / State/Country / Zip		

STATE MEDICAL BOARD OF OHIO
92 APR 27 AM 8:39

C.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
TO	Street & Number		
	City / State/Country / Zip		

D.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
TO	Street & Number		
	City / State/Country / Zip		

AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 05/19/92

NAME: PARKER, WILLIE JAMES
SCHOOL: UNIV OF IOWA COL MED, IOWA CITY IA
DEGREE CONFERRED: MD
DATE CONFERRED: 05/04/90

INTERNSHIP

HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

RESIDENCY

HOSPITAL: UNIV OF CINCINNATI
CITY: CINCINNATI ST: OH
STARTING DATE: 07/90 ENDING DATE: 04/92
HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

FLEX EXAM

DATE OF EXAM: 06/90 STATE EXAM WAS TAKEN: IA

OLD FLEX

RS: % CS: %
CC: % FWA: %
BASIS: FLEX

NEW FLEX

COMPONENT_I: 080%
COMPONENT_II: 080%
BASIS_ST: IA

LETTERS OF RECOMMENDATION

NAME: LAUREN DUNGY, MD CITY: CINCINNATI STATE: OH
NAME: ELBERT NELSON, MD CITY: CINCINNATI STATE: OH

SPECIALITY CODE:
CODE:
CODE:

SPECIALITY BOARD:

	NOT IN	OK	N/A
AMA/AOA:		X	
TSE SCORE:			X
FED INFO:		X	
REC FORM:		X	
ECFMG:			X

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. AGRESTA, MD			
RAYMOND ALBERT			
ANAND G. GARG, MD			
THOMAS E. GRETTER, MD	✓		
ROBERT S. HEIDT, MD			
THERESA M. HOM, DO			
TIMOTHY JOST			
RONALD J. KAPLANSKY, DPM			
CARLA S. O'DAY, MD			
CAROL ROLFES			
TIMOTHY L. STEPHENS, JR., MD			
CHARLES DENNY STIENECKER, MD			

STATE MEDICAL BOARD OHIO
92 MAY 28 AM 10:16

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

List ALL activities in chronological order from the date of medical school graduation to the present time using MONTH and YEAR. For any non-working time, you must state on the resume exactly what your activities were, such as "looking for residency program" or "vacation", as well as your permanent address for this period. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an "emergency medical group" or did locum tenens, you must list all hospitals where you worked and include complete dates and addresses. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, attach separate sheets.

Parker

	month/year	TO	month/year	Hospital, University or Other: / Complete Street Address: / Street & Number / City / State/Country / Zip	Position & Department	% Clinical / % Admin.
A.	07 90	TO	04 92	University of Cincinnati Hospital 234 Goodman Street Cincinnati OH 45220	Resident Physician, Obstetrics and Gynecology	100
B.		TO				
C.		TO				
D.		TO				

AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 05/19/92

NAME: PARKER, WILLIE JAMES
SCHOOL: UNIV OF IOWA COL MED, IOWA CITY IA
DEGREE CONFERRED: MD
DATE CONFERRED: 05/04/90

INTERNSHIP

HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

RESIDENCY

HOSPITAL: UNIV OF CINCINNATI
CITY: CINCINNATI ST: OH
STARTING DATE: 07/90 ENDING DATE: 04/92
HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

FLEX EXAM

DATE OF EXAM: 06/90 STATE EXAM WAS TAKEN: IA

OLD FLEX

RS: % CS: %
CC: % FWA: %
BASIS: FLEX

NEW FLEX

COMPONENT_I: 080%
COMPONENT_II: 080%
BASIS_ST: IA

LETTERS OF RECOMMENDATION

NAME: LAUREN DUNGY, MD CITY: CINCINNATI STATE: OH
NAME: ELBERT NELSON, MD CITY: CINCINNATI STATE: OH

SPECIALITY CODE:
CODE:
CODE:

SPECIALITY BOARD:

	NOT IN	OK	N/A
AMA/AOA:		X	
TSE SCORE:			X
FED INFO:		X	
REC FORM:		X	
ECFMG:			X

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. ARRESTA, MD			
RAYMOND ALBERT			
ANAND G. GARG, MD			
THOMAS E. GRETTER, MD			
ROBERT S. HEIDT, MD			
THERESA M. HOM, DO			
TIMOTHY JOST			
DONALD J. KAPLANSKY, DPM			
CARLA S. O'DAY, MD			
CAROL ROLFES			
TIMOTHY L. STEPHENS, JR., MD			
CHARLES DENNY STIENECKER, MD			

STATE MEDICAL BOARD OF OHIO
92 MAY 22 AM 9:43

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

List ALL activities in chronological order from the date of medical school graduation to the present time using MONTH and YEAR. For any non-working time, you must state on the resume exactly what your activities were, such as "looking for residency program" or "vacation", as well as your permanent address for this period. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an "emergency medical group" or did locum tenens, you must list all hospitals where you worked and include complete dates and addresses. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, attach separate sheets.

Parker

	month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
A.	07 90 month/year TO 04 92 month/year	University of Cincinnati Hospital; 234 Goodman Street (Street & Number); Cincinnati OH 45220 (City State/Country Zip)	Resident Physician, Obstetrics and Gynecology	100 /
B.	month/year TO month/year	Street & Number; City State/Country Zip		
C.	month/year TO month/year	Street & Number; City State/Country Zip		
D.	month/year TO month/year	Street & Number; City State/Country Zip		

STATE MEDICAL BOARD OF OHIO
92 APR 21 AM 8:39

AMERICAN MEDICAL GRADUATE
ENDORSEMENT OF OUT-OF-STATE LICENSES

DATE: 05/19/92

NAME: PARKER, WILLIE JAMES
SCHOOL: UNIV OF IOWA COL MED, IOWA CITY IA
DEGREE CONFERRED: MD
DATE CONFERRED: 05/04/90

INTERNSHIP

HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

RESIDENCY

HOSPITAL: UNIV OF CINCINNATI
CITY: CINCINNATI ST: OH
STARTING DATE: 07/90 ENDING DATE: 04/92
HOSPITAL:
CITY: ST:
STARTING DATE: / ENDING DATE: /

FLEX EXAM

DATE OF EXAM: 06/90 STATE EXAM WAS TAKEN: IA

OLD FLEX

RS: % CS: %
CC: % FMA: %
BASIS: FLEX

NEW FLEX

COMPONENT_I: 080%
COMPONENT_II: 080%
BASIS_ST: IA

LETTERS OF RECOMMENDATION

NAME: LAUREN DUNGY, MD	CITY: CINCINNATI	STATE: OH
NAME: ELBERT NELSON, MD	CITY: CINCINNATI	STATE: OH

SPECIALITY CODE:
CODE:
CODE:

SPECIALITY BOARD:

	NOT IN	OK	N/A
AMA/AOA:		X	
TSE SCORE:			X
FED INFO:		X	
REC FORM:		X	
ECFMG:			X

	APPROVE	DISAPPROVE	ABSTAIN
RONALD C. ARGESTA, MD			
RAYMOND ALBERT			
ANAND G. GARG, MD			
THOMAS E. GRETTER, MD			
ROBERT S. HEIDT, MD			
THERESA M. HOM, DO			
TIMOTHY JOST			
RONALD J. KAPLANSKY, DPM			
CARLA S. O'DAY, MD			
CAROL ROLFES	✓		
TIMOTHY L. STEPHENS, JR., MD			
CHARLES DENNY STIENECKER, MD			

RESUME - MEDICINE OR OSTEOPATHIC MEDICINE

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Parker

A.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
07 90 month/year TO 04 92 month/year	University of Cincinnati Hospital 234 Goodman Street (Street & Number) Cincinnati OH 45220 (City / State/Country / Zip)	Resident Physician, Obstetrics and Gynecology	100 /

B.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
month/year TO month/year	Street & Number City / State/Country / Zip		

STATE MEDICAL BOARD OF OHIO
92 APR 21 AM 8:39

C.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
month/year TO month/year	Street & Number City / State/Country / Zip		

D.

month/year	Hospital, University or Other: / Complete Street Address:	Position & Department	% Clinical / % Admin.
month/year TO month/year	Street & Number City / State/Country / Zip		

I HEREBY CERTIFY THAT I HAVE RECEIVED MY WALL CERTIFICATE

NUMBER 063458, ON 7/28/92
(Date)

Willie J. Parker
Name

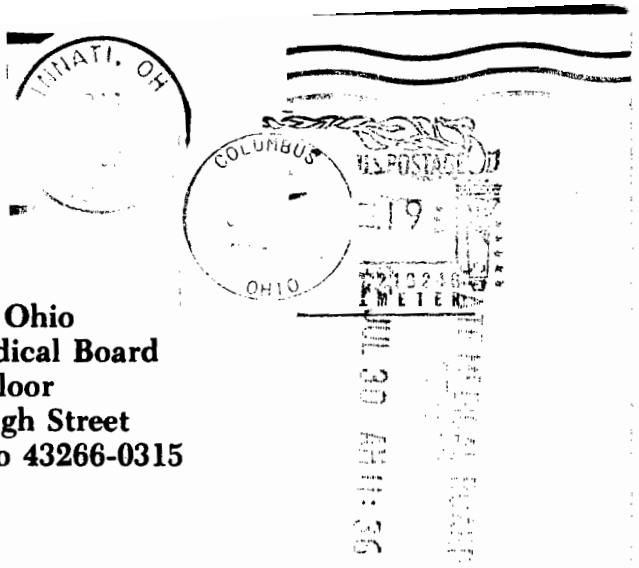
143 Goethe #2
Street Address

Cinti OH / Hamilton 45210
City State/County Zip

Parker MD
Signature

PLEASE CHECK IF THIS IS A CHANGE OF ADDRESS _____

MED 1013 (4/89)



State of Ohio
The State Medical Board
17th Floor
77 South High Street
Columbus, Ohio 43266-0315

DETACH HERE AND REMIT THIS PORTION WITH FEE

STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OHIO 43266 - 0315

CERTIFICATION

I CERTIFY, UNDER PENALTY OF LOSS OF MY RIGHT TO PRACTICE IN THE STATE OF OHIO, THAT I HAVE COMPLETED OR WILL HAVE COMPLETED DURING THE 1992-1994 BIENNIUM THE REQUISITE HOURS OF CONTINUING MEDICAL EDUCATION CERTIFIED BY THE OHIO STATE MEDICAL ASSOCIATION AND APPROVED BY THE STATE MEDICAL BOARD, AND THAT THE INFORMATION PROVIDED ON THIS APPLICATION FOR RENEWAL IS TRUE AND CORRECT IN EVERY RESPECT.

X [signature] 4/11/94
(SIGNATURE OF APPLICANT) (DATE)

IDENTIFICATION NUMBER	AMOUNT DUE	DATE DUE
35-06-3458	$250.00	05/01/94

WILLIE JAMES PARKER,M.D.
143 GOETHE ST
APT 2
CINCINNATI OH 45210

MD & DO SPECIALTY CODES CURRENTLY ON RECORD

NOT ON FILE
OBG

PLEASE VERIFY SPECIALTY CODE(S) CORRECT AS LISTED

IF CORRECTIONS ARE NECESSARY, PLEASE ENTER ALL SPECIALTY CODES. CODE1: OBG CODE2: CODE3:

REPORT ANY CHANGE OF ADDRESS

STREET
513 MULBERRY
STREET
CINCINNATI OH 45210
CITY STATE ZIP CODE
HAMILTON
COUNTY

:969696962: 093506345 8 " "00000 25000"

PRINCIPAL PRACTICE ADDRESS - IF DIFFERENT FROM THE ADDRESS SHOWN ON FRONT:

[illegible]
Street
Street
City State Zip Code
County

AT ANY TIME SINCE SIGNING YOUR LAST APPLICATION FOR RENEWAL OF YOUR CERTIFICATE HAVE YOU:

1.) Been found guilty of, or pled guilty or no contest to a felony or misdemeanor. YES [ ] NO [ ]

2.) Been found guilty of, or pled guilty or no contest to a federal or state law regulating the possession, distribution or use of any drug? YES [ ] NO [ ]

3.) Been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer "no" to this question if you have successfully completed treatment at a program approved by this board and have subsequently adhered to all statutory requirements as contained in sections 4731.224 and 4731.25 O.R.C., and related provisions, or you are currently enrolled in a board approved program. Any questions concerning approval can be directed to the board offices. YES [ ] NO [ ]

4.) Had malpractice insurance cancelled or limited for other than failure to pay premiums? YES [ ] NO [ ]

5.) Had any disciplinary action taken or initiated against you by any state licensing board other than the State Medical Board of Ohio? YES [ ] NO [ ]

6.) Surrendered, or consented to limitation upon: a) A license to practice medicine; OR b) State or federal privileges to prescribe controlled substances? YES [ ] NO [ ]

7.) Had any clinical privileges suspended, restricted or revoked for reasons other than failure to maintain records or attend staff meetings? YES [ ] NO [ ]

8.) After January 14, 1993, referred a patient, or participated in an arrangement or scheme for referral of a patient, for clinical laboratory services to a person or facility in which either you or a member of your immediate family has an ownership or investment interest, or any compensation arrangement? YES [ ] NO [ ]

002ZD 051794 00250 [illegible]
BATCH # DATE REC'D 250.00 051 [illegible] 935063458
AMOUNT BATCH DATE ACCOUNT #

SOCIAL SECURITY NUMBER (Optional for purposes of identification)

Redacted

62774

FOR BOARD USE ONLY		
BK:_____	PG:_____	LN:_____
DATE:_____	FEE: $405.00	PMT:_____

APPLICATION FOR LICENSE RESTORATION MEDICINE OR OSTEOPATHIC MEDICINE

PLEASE TYPE OR PRINT CLEARLY

IDENTIFICATION

Social Security Number:	Redacted Your Social Security number is required to facilitate reporting to the Federal Healthcare Integrity & Protection Data Bank (42 U.S.C. § 1320a-7e(b), 5 U.S.C. § 552a, and 45 C.F.R. pt 61); and accurate identification under the federal and state child support enforcement law (42 U.S.C. §666 and §3123.50, O.R.C.). It also may be used for reporting to the National Practitioner Data Bank (42 U.S.C. §11101 and 45 C.F.R. pt 60) 4731., 4760. or 4762 O.R.C. or as otherwise required by state or federal law.			
Full Name (Use no initials)	Last (Surname): Parker	First: Willie	Middle: James	Suffix (Jr., II):
Maiden Name or Other Names Used (If none, enter "NONE"):	Last (Surname): None	First:	Middle:	Suffix (Jr., II):
Current Home Address **IMPORTANT** Notify the Board office immediately in writing of any change in address	Number and Street: 635	Liberty Pointe	Apt.:	
	City: Ann Arbor	State: MI	Zip Code: 48103	Country: Washtenaw
Telephone Number	Business: area code & number (734)		Home: area code & number (808) 271-0260	
Birth Date	month/day/year: 10/18/62	Birth Place: City: Birmingham	State: AL	Country: USA
Physical Description	Height: 5'11"	Weight: 225	Hair Color: black/bald	Eye Color: Brown	Identifying marks: none
Gender	☑ Male ☐ Female	For statistics only (optional)		
E-mail Address	Berean86WP@yahoo.com			
Plans of practice in Ohio	Women's health in the Cleveland area.			

OHIO STATE MEDICAL BOARD

AUG 24 2007

RECEIVED

CONTINUED ⇨

LICENSES IN THE UNITED STATES AND CANADA

List ALL states/provinces in which you hold or have held a license to practice medicine and surgery or osteopathic medicine and surgery, including a temporary license, training certificate, educational permit, or other license or certificate, ***whether the license is current or not***. If additional space is needed, attach an extra sheet. **(If none, enter "N/A"). A Form 2, Verification of License, must be sent to each state listed.**

STATE/PROVINCE	ISSUE DATE (MO/YR)	LICENSE NO.	LICENSE CURRENT YES	LICENSE CURRENT NO	EXPIRE(S)
Iowa	3/92	28574	☐	☑	10/10/94
OHIO	5/92	63458	☐	☑	9/30/96
CA	5/94	A 053102	☑	☐	10/30/07
HI	10/2001	11733	☑	☐	1/2008
MI	6/06	4301087686	☑	☐	1/31/2010
			☐	☐	
			☐	☐	
			☐	☐	

SPECIALTY BOARDS

NAME OF SPECIALTY BOARD (If none, enter "N/A")	YEAR CERTIFIED	COUNTRY
ABOG	1996	USA

SPECIALTIES

Below you will find a list of specialties for M.D.'s and D.O.'s. Each corresponding specialty is represented by a code. Please fill in the specialty code number corresponding to your correct specialty/specialties below. The specialty you indicate below will be printed in the Roster of Registered Physicians and Podiatrists.

EXAMPLES: **Code: AN - Anesthesiology** **Code: PD - Pediatrics**

SPECIALITIES (please fill in): | OBG | | |

SPECIALTY CODES

CODE	DESCRIPTION
AS	Abdominal Surgery
ADM	Addiction Medicine
ADP	Addiction Psychiatry
AMI	Adolescent Medicine (Internal Medicine)
ADL	Adolescent Medicine (Pediatrics)
OAR	Adult Reconstructive Orthopedics
AM	Aerospace Medicine
A	Allergy
AI	Allergy & Immunology
ALI	Clinical Laboratory Immunology (All & Imm)
PTH	Anatomic/Clinical Pathology
ATP	Anatomic Pathology
AN	Anesthesiology
BBK	Blood Banking/Transfusion Medicine
ICE	Clinical Cardiac Electrophysiology
CTS	Cardiothoracic Surgery
CD	Cardiovascular Diseases
CDS	Cardiovascular Surgery
PCH	Chemical Pathology
CHP	Child and Adolescent Psychiatry
CHN	Child Neurology
CBG	Clinical Biochemical Genetics
CCG	Clinical Cytogenetics
CG	Clinical Genetics
DDL	Clinical & Lab. Dermatological Immunology
ILI	Clinical & Lab. Immunology (Int. Med.)
PLI	Clinical & Lab. Immunology (Pediatrics)
CMG	Clinical Molecular Genetics
CN	Clinical Neurophysiology
CLP	Clinical Pathology
PA	Clinical Pharmacology
CRS	Colon & Rectal Surgery
CCA	Critical Care Medicine (Anesthesiology)
CCM	Critical Care Medicine (Internal Medicine)
NCC	Critical Care Medicine (Neurological Surg.)
OCC	Critical Care Medicine(OB-GYN)
PCP	Cytopathology
CODE	**DESCRIPTION**
D	Dermatology
DMP	Dermatopathology (Pathology)
DMD	Dermatopathology (Dermatology)
DS	Dermatologic Surgery
DIA	Diabetes
DR	Diagnostic Radiology
EM	Emergency Medicine
END	Endocrinology, Diabetes & Metabolism
EP	Epidemiology
FPS	Facial Plastic Surgery
FP	Family Practice
FOP	Forensic Pathology
PFP	Forensic Psychiatry
GE	Gastroenterology
GP	General Practice
GPM	General Preventive Medicine
GS	General Surgery
FPG	Geriatric Medicine (Family Practice)
IMG	Geriatric Medicine (Internal Medicine)
PYG	Geriatric Psychiatry
GYN	Gynecology
GO	Gynecological Oncology
HS	Hand Surgery (Orthopedic Surgery)
HNS	Head & Neck Surgery
HEM	Hematology (Internal Medicine)
HMP	Hematology (Pathology)
HO	Hematology/Oncology
HEP	Hepatology
IG	Immunology
PIP	Immunopathology
ID	Infectious Diseases
IM	Internal Medicine
MPD	Internal Medicine/Pediatrics
LM	Legal Medicine
MFM	Maternal & Fetal Medicine
MXR	Maxillofacial Radiology
MG	Medical Genetics
CODE	**DESCRIPTION**
MDM	Medical Management
MM	Medical Microbiology
ON	Medical Oncology
ETX	Medical Toxicology (Emer. Med)

PDT	Medical Toxicology (Pediatrics)
PTX	Medical Toxicology (Prevent. Med.)
OMO	Musculoskeletal Oncology
NPM	Neonatal-Perinatal Medicine
NEP	Nephrology
N	Neurology
NRN	Neurology/Diag. Radiology/Neuroradiology
NS	Neurological Surgery
NP	Neuropathology
RNR	Neuroradiology
NM	Nuclear Medicine
NR	Nuclear Radiology
NTR	Nutrition
OBS	Obstetrics
OBG	Obstetrics & Gynecology
OM	Occupational Medicine
OPH	Ophthalmology
ORS	Orthopedic Surgery
OSS	Orthopedic Surgery of the Spine
OTR	Orthopedic Trauma
OFA	Foot & Ankle, Orthopedics
OMM	Osteopathic Manipulative Medicine
OTO	Otolaryngology
OT	Otology/Neurotology
APM	Pain Management (Anesthesiology)
PDM	Pain Medicine
PLM	Palliative Medicine
PDA	Pediatric Allergy
PDC	Pediatric Cardiology
CCP	Pediatric Critical Care Medicine
PE	Pediatric Emergency Medicine (Emer. Med)
PEM	Pediatric Emergency Medicine (Pediatrics)
PDE	Pediatric Endocrinology
PG	Pediatric Gastroenterology
PHO	Pediatric Hematology/Oncology
PDI	Pediatric Infectious Disease
PN	Pediatric Nephrology
PO	Pediatric Ophthalmology
OP	Pediatric Orthopedics

CODE	DESCRIPTION
PDO	Pediatric Otolaryngology
PP	Pediatric Pathology
PDP	Pediatric Pulmonology
PDR	Pediatric Radiology
PPR	Pediatric Rheumatology
NSP	Pediatric Surgery (Neurology)
PDS	Pediatric Surgery (Surgery)
UP	Pediatric Urology
PD	Pediatrics
PM	Physical Medicine & Rehabilitation
PS	Plastic Surgery
PRO	Proctology
P	Psychiatry
PYA	Psychoanalysis
MPH	Public Health & General Preventive Med.
PCC	Pulmonary Critical Care Medicine
PUD	Pulmonary Disease
RO	Radiation Oncology
RP	Radiological Physics
R	Radiology
RIP	Radioisotopic Pathology
REN	Reproductive Endocrinology
RHU	Rheumatology
SP	Selective Pathology
SM	Sleep Medicine
SCI	Spinal Cord Injury
ESM	Sports Medicine (Emergency Medicine)
FSM	Sports Medicine (Family Practice)
ISM	Sports Medicine (Internal Medicine)
OSM	Sports Medicine (Orthopedic Surgery)
PSM	Sports Medicine (Pediatrics)
HSP	Hand Surgery (Plastic Surgery)
HSS	Surgery of the Hand (Surgery)
CCS	Surgical Critical Care (Surgery)
SO	Surgical Oncology
TS	Thoracic Surgery
TRS	Trauma Surgery
TTS	Transplant Surgery
UM	Undersea Medicine
U	Urology
VIR	Vascular & Interventional Radiology
VS	Vascular Surgery
OS	Other (i.e., specialty other than those listed)
US	Unspecified

RESUME - LICENSE RESTORATION - MEDICINE OR OSTEOPATHIC MEDICINE

List ALL activities in chronological order from the date your license expired or the last ten years; whichever is shorter to the present time, using **MONTH** and **YEAR**. For any non-working time, you MUST state on the resume exactly what your activities were, such as "vacation" or "looking for work", as well as your permanent address. If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an "emergency medical group" or did locum tenens, you must list all hospitals where you worked and include complete dates and addresses. DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM. Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, attach separate sheets.

A

month/year TO	Hospital, University or Other:	Position & Department	% Clinical
6 94	Golden Valley Community Health Ctr ~~Merced Comm. Medical Ctr~~	Staff Physician OB/Gyn Women's Health	99
6 97 month/year	Complete Street Address: 797 W. Childs Avenue (Number & Street) Merced CA 9 (City State/Country Zip Code)		% Admin. 1

B

month/year TO	Hospital, University or Other:	Position & Department	% Clinical
7 97	Harvard School of Public Hea	Masters Degree Public Health (School full time) (no practice)	
6 98 month/year	Complete Street Address: 677 Huntington Ave (Number & Street) Boston MA USA (City State/Country Zip Code)		% Admin.

C

month/year TO	Hospital, University or Other:	Position & Department	% Clinical
7 98	(National Public Health Service) CDC EPIDEMIC INT. SERVICE		100
6 00 month/year	Complete Street Address: 1600 Clifton Road, NE MS E-92 (Number & Street) Atlanta GA USA (City State/Country Zip Code)	EIS Officer Public Health Service	% Admin.

D

month/year TO	Hospital, University or Other:	Position & Department	% Clinical
4 99	UC Davis Med. Ctr	Volunteer Clinical Faculty OB-Gyn Dept	100
12 01 month/year	Complete Street Address: 4860 Y Street, Ste 2500 (Number & Street) Sacramento CA 95817-2307 (City State/Country Zip Code)		% Admin.

OVER ⇨

RESUME - LICENSE RESTORATION - MEDICINE OR OSTEOPATHIC MEDICINE
PAGE TWO

	month/year FROM	month/year TO	Hospital, University or Other: / Complete Street Address: / Number & Street / City / State/Country / Zip Code	Position & Department	% Clinical / % Admin.
E	1 02	6 06	Queens Med Ctr / Univ of HI 1301 Punchbowl Street Honolulu HI USA 96813	Asst. Professor OB-Gyn OB-Gyn Dept	95 5
F	06 06	present	University of Michigan 1500 E. Med Ctr Drive Ann Arbor MI 48103	Fellow/ Clinical Instructor OB-Gyn Dept	100
G					
H					

Vest, Peri

From: Willie Parker [berean86wp@yahoo.com]
Sent: Monday, September 24, 2007 08:56 AM
To: Vest, Peri
Subject: Fwd: Re: Greetings for Willie Parker....request assistance

Ms. Vest-

The following timeline indicates my practice activities for the past 10 years, related to requests verification of claim actions. I submit this to indicate and confirm from whom I need to obtain statements. I submitted the only two incidents where I have been named in a suit.

1997-2001- Attended public health school and work for the Centers for Disease control as a medical epidemiologist. No malpractic coverage and clinical practice.

2002-2006-Queens Medical Center- verifiable by email below. As you can note from the forwarded email, they asked that I have you request directly, and they will copy me. I do not have a form to send to them, and I am surprised that the note from you that I forwarded did not suffice. Can you send the email request to Mr. Kahaulelio as requested, or inform me how to proceed?

2006-present. I will request that Jane Juckno from the University of Michigan send you a note or have someone from risk management send a note.

Thank you for all of your attention. I don't know if all that you have done for me falls under your routine scope of duties, but you have made me feel like you have gone the extra mile for me at every turn, facilitating this process, and for that I am greatly appreciative. Once this is done, I would like to write a letter of appreciation to whomever appropriate about you high degree of professionalism in carrying out your duties. Thank you very much.

Willie J. Parker, MD

DAVID KAHAULELIO <DKAHAULELIO@queens.org> wrote:

> Date: Fri, 21 Sep 2007 07:45:37 -1000
> From: "DAVID KAHAULELIO" <DKAHAULELIO@queens.org>
> To: "BOB HEE" <BHEE@queens.org>,
> berean86wp@yahoo.com
> CC: "Judy KUSAKA" <JKUSAKA@queens.org>
> Subject: Re: Greetings for Willie Parker....reques assistance
>
> Aloha,
>
> We can provide the verification required for Willie's employment at
> Queen's.
>
> Bob,
> Please confirm the employment period.

Willie,
Please have Peri Vest send a request to us directly. We will respond and copy you.

Mahalo, Dave

David Kahaulelio
Vice President, Risk Management
Queen's Health Systems
1099 Alakea Street, Suite 1100
Honolulu, Hawaii 96813
Phone: 808.532.6121
Fax: 808.532.6122

>>> BOB HEE 09/21/07 07:41AM >>>
HI, Dr. Parker, glad to hear that everything is fine with you. I'm doing okay myself. I've copied Judy and David from our Risk Management Department to advise you further. My number is (808) 547-4063. Thanks.

>>> "Willie Parker" 09/21/07 03:13AM >>>

Bob:
Greetings from Michigan. I hope that you are well. I am well here. The fellowship is rewarding on different levels. I am applying for reactivation of my license in the state of Ohio. They have request a report of claims from my malpractice carrier for the past ten years. My most rececent carrier besides the University of Michigan was Queens. I know that Queens is self indemnified to a point, with secondary coverage that kicks in at a certain point. I will include the request in the body of this email, but can you forward this to the person at QMC who can provide this information. and have them contact me so that I can complete this application? Also can you have them send me documentation that I would need in the future to respond to these type requests? Thanks in advance for your help. I'll await confirmation of your response. Also can you forward me your phone number so that I can reach you if I need to elaborate on this issue?

QUEEN'S INSURANCE EXCHANGE, INC.

1099 Alakea Street, Suite 1100 • Honolulu, Hawaii 96813 • Phone: (808) 532-6119 • FAX: (808) 532-6122

Via E-mail (Peri.Vest@med.state.oh.us)

September 25, 2007

State Medical Board of Ohio

Re: Dr. Willie Parker

Attention: Peri Vest

We are in receipt of your E-mail requesting verification of claims history under our professional liability program for Dr. Willie Parker. Dr. Parker was an employee of The Queen's Medical Center from January 1, 2002 to April 28, 2006.

Our records for the period noted above show that Dr. Parker has one claim pending – date of loss of 10/29/2003 with a total incurred to date of $130,000.

If you have any questions, please contact us at (808)532-6119.

Sincerely,

David Kahaulelio

David Kahaulelio
President

cc: Willie Parker (Via E-mail berean86wp@yahoo.com)

University of Michigan
Health System

UMHS Risk Management Department
300 North Ingalls, Room 8A06
Ann Arbor, MI 48109-0478
(734) 763-5456
(734) 763-5300 fax

September 25, 2007

PREPARED FOR: State Medical Board of Ohio
Attn: Ms. Peri Vest

RE:	Name:	Willie James Parker, M.D.
	Dates of Coverage:	7/1/2006 – Present (upon termination of employment)
	Policy #:	VMPL-2006 (Veritas)
	Type of Coverage:	Occurrence
	Policy Limits:	$1M Occurrence / $3M Aggregate

To Whom It May Concern:

This letter serves as verification of professional liability insurance coverage and claims history with Veritas Insurance Corporation for activities performed as an employee through The University of Michigan for the dates of coverage shown above. Coverage does not apply to offsite activities not approved by the University or to activities that are not within their scope of duties for The University of Michigan.

According to our records, the above named physician has not been named in any malpractice suits or claims to date.

Sincerely,

Susan Adera

Susan G. Anderson
Director, UMHS Risk Management Department

SGA:jb
Sent via facsimile: 614.644.1464

UMHS Risk Management
300 North Ingalls, Room 8A06
Ann Arbor, MI 48109-0478
Phone: 734.763.5456 Fax: 734.763.5300

CONFIDENTIAL

FAX

OVER ⇨

		YES	NO
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☑
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☑
12.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
13.	Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
14.	Have you ever been denied or have you ever surrendered a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☑
15.	Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation?	☐	☑
16	Have you ever forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)?	☐	☑
17.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, include the case name, case number, court and address, date filed, and a summary of the underlying events. Indicate current status, including amount of settlement or judgment, if any. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board. see attached	☑	☐
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☑
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☑
20.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☑

ADDITIONAL LICENSE RESTORATION INFORMATION
MEDICINE OR OSTEOPATHIC MEDICINE

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. You must submit copies of all relevant documentation, such as court pleadings, court or agency orders, and institutional correspondence and orders. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

(Please place a ☑ in the yes or no box)

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☑
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☑
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☑
4.	Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, residency, or graduate medical education program?	☐	☑
5.	Have you ever transferred from one graduate medical education program to another?	☐	☑
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☑
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☑
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☑
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☑

		YES	NO
21.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism? If yes, please explain	☐	☑
22.	a) Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑
	b) Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑

If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

For purposes of questions 23 and 24 the following phrases or words have the following meaning:

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

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

		YES	NO
23.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain.	☐	☑
	a) Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program? If yes, please explain.	☐	☑
	b) Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	☐	☑

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

Chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

		YES	NO
24.	Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?	☐	☑
	a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.	☐	☑
	b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	☐	☑

For purposes of question 25 the following phrases or words have the following meaning:

"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 use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

		YES	NO
25.	Are you currently engaged in the illegal use of controlled substances?	☐	☑
	a) If "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 using illegal controlled substances.	☐	☑

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

LICENSE RESTORATION - MEDICINE OR OSTEOPATHIC MEDICINE
FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known the applicant for at least **SIX months**. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. **This form must be notarized by the recommending physician**. ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM
BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, VANESSA DALTON (recommending physician, print name), a licensed and practicing physician in the state of MICHIGAN (state of residence),

affirm that WILLIE PARKER (applicant, print name) has been known to me personally for 1.5 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: EXCELLENT
- His/her relationship with patients is: EXCELLENT
- I rate his/her ability to work well with peers and medical staff as: EXCELLENT
- His/her command of the English language is: PERFECT
- Additional comments:

I hereby recommend him/her for restoration of his/her license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street: 1500. E. MEDICAL CENTER DR City: ANN ARBOR State: MI Zip Code: 48109	Telephone Number (include area code)	734.647.9726
Signature of Recommending Physician (name stamps not acceptable)		State of Licensure & License Number	MI DV0704 90

Signature of Applicant

Date Photo Taken: 05 / 07 (Mo/Yr)

Subscribed and sworn to before me this 23 day of August, 2007.

Notary Public Signature

Date Commission Expires 07/11/2012

JANE E. JUCKNO
Notary Public, State of Michigan
County of Livingston
My Commission Expires Sep. 11, 2012
Acting in the County of Washtenaw

NOTARY SEAL

RETURN COMPLETED FORM TO THE STATE MEDICAL BOARD OF OHIO AT THE ABOVE ADDRESS

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.state.oh.us/med/

LICENSE RESTORATION - MEDICINE OR OSTEOPATHIC MEDICINE
FORM 1 - CERTIFICATE OF RECOMMENDATION

This form is to be completed by a physician fully licensed in the STATE IN WHICH THE FORM IS NOTARIZED. The recommending physician must have known the applicant for at least **SIX months**. Relatives may not serve as recommending physicians. Recommending physicians are strongly urged to include additional comments. **This form must be notarized by the recommending physician.** ALL questions must be answered. This form is not intended to standardize the recommendation or restrict it in any way. However, its form is designed to ensure that certain information is included.

DO NOT COMPLETE UNLESS A COLOR PHOTO OF APPLICANT IS ATTACHED TO THE BOTTOM OF THIS FORM
BLACK & WHITE PHOTOS ARE NOT ACCEPTABLE

I, Timothy RB Johnson (recommending physician, print name), a licensed and practicing physician in the state of Michigan (state of residence),

affirm that Willie Parker (applicant, print name) has been known to me personally for 1 years and that he/she is of good moral character. Further, the photograph affixed hereto is a genuine likeness of the applicant. I offer the following in support of his/her application for licensure:

- I rate his/her medical knowledge and technique as: excellent
- His/her relationship with patients is: excellent
- I rate his/her ability to work well with peers and medical staff as: excellent
- His/her command of the English language is: native
- Additional comments:

I hereby recommend him/her for restoration of his/her license to practice medicine or osteopathic medicine in the State of Ohio.

Address of Recommending Physician	Number & Street: 1500 E Medical Center Drive City: Ann Arbor State: MI Zip Code: 48109	Telephone Number (include area code)	734-764-8123
Signature of Recommending Physician (name stamps not acce		State of Licensure & License Number	Michigan 4301-060938

Signature of Applicant

Date Photo Taken: 05 / 07 (Mo/Yr)

Subscribed and sworn to before me this 22 day of August, 2007.

Notary Public Signature

Date Commission Expires 09/11/2012

JANE E. JUCKNO
Notary Public, State of Michigan
County of Livingston
NOTARY SEAL
My Commission Expires Sep. 11, 2012
Acting in the County of Washtenaw

RETURN COMPLETED FORM TO THE STATE MEDICAL BOARD OF OHIO AT THE ABOVE ADDRESS

LICENSE RESTORATION - MEDICINE OR OSTEOPATHIC MEDICINE
AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release below MUST be completed by **ALL** applicants. The form must be notarized. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered incomplete.

ss STATE OF: Michigan
COUNTY OF: Washtenaw

I, Willie James Parker, hereby certify under oath that I am the person named in this application for restoration to practice medicine or osteopathic medicine in the State of Ohio; 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 to this Board 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 respect.

I acknowledge that I have read the general information and instructions, and have answered all questions in compliance with these instructions and understand that the fee I submitted is neither refundable nor transferable.

I further state that by filing this application for restoration to practice medicine or osteopathic medicine in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for a license to practice medicine or osteopathic medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that my application for restoration to practice medicine or osteopathic medicine in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change occours at any time prior to restoration to practice medicine or osteopathic medicine being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for a license to practice medicine or osteopathic medicine and that any fee I submitted is neither refundable nor transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives and any person furnishing information of any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

I further understand that issuance of restoration to practice medicine or osteopathic medicine in Ohio will be considered based on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said certificate.

W Parker
Signature of Applicant

Subscribed and sworn to before me this 22 day of August 2007.

Jane E Juckno
Signature of Notary Public

(NOTARY SEAL)

09/11/2012
Date Commission Expires

JANE E. JUCKNO
Notary Public, State of Michigan
County of Livingston
My Commission Expires Sep. 11, 2012
Acting in the County of Washtenaw

CERTIFICATION OF CONTINUING MEDICAL EDUCATION FOR THE PERIOD OF JANUARY 2, 2004 - JANUARY 1, 2006 (N-R)

100 CREDITS REQUIREMENT:	AT LEAST 40 CREDITS MUST BE EARNED IN CATEGORY 1.

I certify the following to be true and correct. This form must be completed, signed and returned.

Marker, MD, MPH — SIGNATURE
8/20/07 — DATE (MO/DAY/YR)
63458 — OHIO CERTIFICATE NUMBER

Parker — NAME LAST
Willie — FIRST
James — MIDDLE
SUFFIX (Jr., II)

635 Liberty Pointe — ADDRESS NUMBER & STREET
Ann Arbor — CITY
MI — STATE
48103 — ZIP CODE

CATEGORY 1
(YOU MUST ATTACH DOCUMENTATION

NAME OF SPONSOR	LOCATION (CITY & STATE)	DESCRIPTION	DATE(S)	CREDITS
EXAMPLE: **Christ Hospital**	**Cincinnati, Ohio**	**Surgery Residency**	**06/01/04 thru 06/01/05**	**50**
ABOG Recert	Ann Arbor MI	Recertification		30

OHIO STATE MEDICAL BOARD
AUG 24 2007
RECEIVED

Revised 12/29/05

PLEASE LIST CATEGORY 2 ON REVERSE SIDE →

Jan 2, 2004 - Jan. 1, 2006

CATEGORY 2

A MAXIMUM OF *60 CREDITS* MAY BE EARNED IN THIS CATEGORY

NAME OF SPONSOR	LOCATION (CITY & STATE)	DESCRIPTION	DATE(S)	CREDITS
Examples: Self Instruction		**Pediatric Journal**	**10/04 thru 06/05**	**60+**

Parker, Willie James

Jan 2, 2004 - Jan. 1, 2006

CATEGORY 2

A MAXIMUM OF *60 CREDITS* MAY BE EARNED IN THIS CATEGORY

NAME OF SPONSOR	LOCATION (CITY & STATE)	DESCRIPTION	DATE(S)	CREDITS
Examples: Self Instruction		**Pediatric Journal**	**10/04 thru 06/05**	**60+**
Self Instruction	Honolulu, HI	Gren Journal	9/04-	25+
Self Instruction	Honolulu, HI	Journ of Reprod. Medicine	12/31/05	25+
Self Instruction	Honolulu, HI	Contemporary OB-Gyn		25+

Parker, Willie James

Parker, MD

Revised 12/29/05

The Queen's Medical Center
CME Transcript Report

Report for Period: 1/1/2003 - 8/5/2007

Prepared on August 6, 2007 for:
WILLIE PARKER, MD

The Queen's Medical Center certifies that the above n amed physician has participated in the following educational activity and is awarded the designated category 1 credit(s) toward the AMA Physician's Recognition Award. (Provider #0006372)

Date	Title of CME Activity	Location	Credits
	OBSTETRICS AND GYNECOLOGY CO NFERENCE		
1/6/2003	Women's Heart Advantage	The Queen's Medical Center, Honolulu, HI	1
1/13/2003	Interesting Laparoscopic Cases		1
1/27/2003	Morbidity and Mortality		1
2/3/2003	Smoking Cessation in Pregnancy		1
3/10/2003	New CDC Guidelines for Prevention of Neonatal GBS Disease		1
3/24/2003	Trauma in Pregnancy		1
3/31/2003	Ductal Lavage: The Breast Pap Smear		
4/7/2003	Ten Year Review of Uterine Ruptures Loca lly		1
4/21/2003	GYN Oncology Morbidity & Mortality		1
5/5/2003	Domestic Violence		1
5/12/2003	Pre-op and Post-op Anesthesia		1
6/2/2003	Morbidity and Mortality		1

THE QUEEN'S MEDI CAL CENTER
Office of Continuing Medical Education
1301 Punchbowl Street • Honolulu, HI 96813 • Phone (8 08) 537-7009 • Fax (808) 585-5040

Date	Title of CME Activity	Location	Credits
6/16/2003	Chlamydia trachomatis & Neisseria gonorrh ea: The Impact of Molecular Diagnostics	The Queen's Medical Center, Honolu	1
6/23/2003	Estrogen and Hormone Therapy		1
7/7/2003	Postterm Pregnancy Overview		1
7/14/2003	Impact of HSV in Pregnancy		1
7/21/2003	Eating Disorders		1
8/4/2003	Morbidity and Mortality		1
8/11/2003	Newborn Metabolic Screening Using Tandem Mass Spectrometry		1
8/18/2003	GYN Oncology Morbidity & Mortality		1
8/25/2003	New Developments in Migraine Pathoph ysiology and Treatment		1
9/8/2003	Pre-Implantation Genetic Diagnosis in Infe rtility Treatment		1
9/22/2003	Morbidity and Mortality		1
9/29/2003	GYN Oncology Morbidity and Mortality		1
10/6/2003	Current Issues in Breastfeeding		1
10/20/2003	Endometriosis - An Evidence-based Appro ach		1
11/3/2003	Advanced Laparoscopic Surgery		1
11/24/2003	Perinatal HIV: 2003 Prevention and Treat ment Update		1
12/8/2003	Myths, Follies of Clinically Evidence-B ased Infertility Treatment		1
12/15/2003	Prevention of Osteoporosis and Hip Frac tures		1
12/29/2003	Practical Obstetric Sonography: Skeletal Dysplasias		1
	EXPANDING THE ROLE FOR ENDOM ETRIAL ABLATION		

Date	Title of CME Activity	Location	Credits
6/5/2003	EXPANDING THE ROLE FOR ENDOMETRI AL ABLATION	The Queen's Medical Center, Honolulu, HI	4
	PRESENTATION SKILLS WORKSHOP F OR PHYSICIANS		
7/12/2003	Presentation Skills Workshop for Physic ians - Morning Workshop - 7/12/03	Queen's Conference Center, Honolulu, HI	3.5
	PEER REVIEW: CAN WE MAKE IT BET TER?		
7/22/2003	PEER REVIEW: CAN WE MAKE IT BETTE R?	Queen's Conference Center, Honolulu, HI	2.5
	OBSTETRICS & GYNECOLOGY CONFE RENCE		
1/5/2004	OBSTETRICS & GYNECOLOGY CONFE RENCE	The Queen's Medical Center, Honolulu, HI	1
1/5/2004	Emergency Contraception		1
1/12/2004	Morbidity and Mortality		1
2/2/2004	GYN Oncology Morbidity & Mortality		1
2/9/2004	Advances in Minimally Invasive Techniques and Technology		1
2/23/2004	Update on Obstetric Ultrasound		1
3/1/2004	Who Decides if Neonatal Resuscitation at the Threshold of Viability is Too High?		1
3/8/2004	The Evolving Management of the Overwe ight and Obese		1
3/15/2004	Morbidity and Mortality		1
3/22/2004	Radiation Risk During Pregnancy		1
3/29/2004	GYN Oncology Morbidity & Mortality		1
4/5/2004	Osteoporosis Update		1
5/3/2004	Female Sexual Dysfunction		1

Date	Title of CME Activity	Location	Credits
5/10/2004	Update in Medical Informatics and Teleme dicine	The Queen's Medical Cent[illegible], Honolulu, H	1
5/17/2004	Alternatives to Estrogen for Menopaus al Symptoms		1
6/7/2004	Successful Vacuum Delivery		1
6/14/2004	Morbidity and Mortality		1
6/21/2004	Trauma in Pregnancy		1
6/28/2004	Lesbian Health		1
7/19/2004	Epilepsy in Pregnancy		1
8/23/2004	Predictors of Sexual Outcome for Hysterec tomy Oophorectomy		1
8/30/2004	Overactive Bladder		1
9/13/2004	Heart Disease in Women		1
9/27/2004	Endometriosis: New Horizons		1
10/4/2004	Advances in the Management of Overact ive Bladder		1
11/1/2004	Morbidity and Mortality		1
11/8/2004	Morbidity and Mortality		1
11/29/2004	GYN Oncology Case Presentations		1
12/13/2004	Surgical Options for Adnexal Masses		1
12/20/2004	Current Sling Techniques for Stress Incont inence		1
	REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY		
9/3/2004	Friday - 9/3/04	Halekulani Hotel, Honolulu, HI	3.5
	MANAGING PATIENT EXPECTATIONS		

Date	Title of CME Activity	Location	Credits
10/19/2004	MANAGING PATIENT EXPECTATIONS	THE QUEEN'S MEDICAL CENTER - L... ROOM	1.5
	OBSTETRIC & GYNECOLOGY GRAND RO UNDS		
1/10/2005	The Postpartum Pelvic Floor	The Queen's Medical Center, Honolulu, HI	1
1/24/2005	GYN Oncology Case Presentations		1
2/7/2005	OB Case Presentations		1
3/7/2005	Preterm Labor Prevention		1
3/21/2005	Morbidity and Mortality		1
3/28/2005	Hormones, Mood, Sexuality and the Meno pause		1
4/11/2005	Another Look at Antenatal Fetal Testing		1
5/2/2005	What the Genetics Team Can Do for You and Your Patients		1
5/9/2005	Morbidity and Mortality		1
5/16/2005	GYN Oncology Case Presentations		1
5/23/2005	Looking behind--anal cancer screening		1
6/6/2005	Intrauterine Growth Restriction (IUGR): Ultrasound on My Mind		1
6/27/2005	Recurrent Miscarriage		1
7/11/2005	Obstetric Hemorrhage		1
7/18/2005	Care of the Preg Cardiac Pt		1
8/1/2005	Preeclampsia - Beyond Hypertension and Proteinuria		1
8/8/2005	Reproductive Options for Cancer Patien ts		1
8/22/2005	GYN Oncology Cases		1

Date	Title of CME Activity	Location	Credits
9/19/2005	Pelvic Reconstructive Surgery with Graft Augmentation: The Vaginal Approach	The Queen's Medical Center, Honolulu, HI	1
10/17/2005	The Genetics Quiz: Genetics in Everyd ay Practice		1
10/31/2005	Morbidity and Mortality		1
11/14/2005	Real Gynecologists Do It From Below		1
12/12/2005	Morbidity and Mortality		1
	CARE*Link Training		
12/6/2005	CLASS A (T6)		4
12/7/2005	CLASS B (T5)		4
12/9/2005	CLASS C (T6)		4
	OBSTETRICS & GYNECOLGY CONFERE NCE		
1/30/2006	Osteoporosis: Detecting and Preventing Me nopausal Morbidity and Mortality	The Queen's Medical Center, Honolulu, HI	1
2/13/2006	Placenta accreta: What Are the Manageme nt Options?		1
2/27/2006	You've caught her in your CAGE, now wh at? Understanding Drugs and Alcohol in Pregnancy		1
4/17/2006	Different minds, different bodies. Adolesce nts: Not just youg adults		1
	PERINATAL CRITICAL EVENTS SIMULATI ON TRAINING		
2/11/2006	PERINATAL CRITICAL EVENTS	THE QUEEN'S MEDICAL CE NTER, HONOLULU, HI	3.5
		Total AMA PRA Category 1 Credits:	117.5

Transcript

Provided by the Hawaii Consortium for Continuing Medical Education

Printed August 27, 2007

For: WILLIE PARKER

Category 1 Credits	Date Earned	Title
1.00	01-19-2005	The Ice Age Revisited
1.00	04-18-2005	Surgery in the Obese Patient

2.00 Total Credits

Signature Date

The Hawaii Consortium for Continuing Medical Education is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education programs for physicians.

The HCCME designates each educational activity listed on this transcript for *AMA PRA Category 1 Credit*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Transcript

Provided by the Hawaii Consortium for Continuing Medical Education

Printed August 27, 2007

For: WILLIE PARKER

Category 1 Credits	Date Earned	Title
1.00	06-02-2004	Gestational Diabetes in the Pacific Population
1.00	10-20-2004	Abortion: From a Public Health Perspective
1.00	12-08-2004	Misoprostol for the Medical Management of Miscarriage

3.00 Total Credits

Juliana Lee 8/27/07

Signature Date

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Transcript

Provided by the Hawaii Consortium for Continuing Medical Education

Printed August 27, 2007

For: WILLIE PARKER

Category 1 Credits	Date Earned	Title
1.00	02-24-2003	Medical Complications in the Obese Gravida
1.00	02-26-2003	Thrombophilias in Pregnancy
1.00	03-17-2003	Reproductive Options and Outcomes for Individuals with Sex Chromosome
1.00	04-09-2003	Domestic Violence and Pregnant Women
1.00	04-16-2003	Dermatoses of Pregnancy
1.00	05-07-2003	Prophylatic Oophorectomy
1.00	06-04-2003	Mucosal Immunity
1.00	06-25-2003	Low Dose Hormone Therapy
1.00	09-17-2003	Emergency Contraception
1.00	10-15-2003	Laparoscopy and Pregnancy
1.00	12-01-2003	Surgical Treatment of Stress Incontinence
1.00	12-10-2003	Total vs. Subtotal Hysterectomy

12.00 Total Credits

Juliana Wood 8/27/07

Signature Date

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University of Michigan
Medical School

CME Report for Continuing Medical Education Programs Attended During 2006

This report documents AMA PRA Category 1 credit earned for programs that took place at the University of Michigan Health System for which an orange attendance/evaluation card was submitted before 12/31/2006. THIS COPY IS FOR YOUR RECORDS. Documentation of this credit is also on file in the Department of Medical Education. Questions should be directed to Tana DeClercq, CME Credit Coordinator, at (734) 936-1664 or tdeclerc@umich.edu.

Participant Name: **Willie Parker, MD, MPH**

Department - Program Name	Program Date	Credit
Obstetrics and Gynecology-Morbidity and Mortality Conference	01/16/2006	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	07/24/2006	1.00
Obstetrics and Gynecology-Perinatal Grand Rounds	07/31/2006	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	08/07/2006	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	08/14/2006	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	08/21/2006	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	09/11/2006	1.00
Obstetrics and Gynecology-Grand Rounds	09/14/2006	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	09/18/2006	1.00
Obstetrics and Gynecology-Grand Rounds	09/21/2006	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	09/25/2006	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	10/02/2006	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	10/16/2006	1.00
Obstetrics and Gynecology-Grand Rounds	10/19/2006	1.00
Obstetrics and Gynecology-Grand Rounds	10/26/2006	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	10/30/2006	1.00
Obstetrics and Gynecology-Grand Rounds	11/02/2006	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	11/06/2006	1.00
Obstetrics and Gynecology-Grand Rounds	11/09/2006	1.00
Anesthesiology-Sedation Analgesia Workshop	11/14/2006	3.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	11/20/2006	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	11/27/2006	1.00
Obstetrics and Gynecology-Perinatal Grand Rounds	12/04/2006	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	12/18/2006	1.00

Total Credit Hours for Willie Parker, MD, MPH **26.00**

University of Michigan
Medical School

CME Report for Continuing Medical Education Programs Attended During 2007

This report documents AMA PRA Category 1 credit earned for programs that took place at the University of Michigan Health System for which an orange attendance/evaluation card was submitted before 12/31/2007. THIS COPY IS FOR YOUR RECORDS. Documentation of this credit is also on file in the Department of Medical Education. Questions should be directed to Tana DeClercq, CME Credit Coordinator, at (734) 936-1664 or tdeclerc@umich.edu.

Participant Name: **Willie Parker, MD, MPH**

Department - Program Name	Program Date	Credit
Obstetrics and Gynecology-Morbidity and Mortality Conference	01/08/2007	1.00
Obstetrics and Gynecology-Grand Rounds	01/17/2007	1.00
Obstetrics and Gynecology-Grand Rounds	01/25/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	01/30/2007	1.00
Obstetrics and Gynecology-Grand Rounds	02/01/2007	1.00
Obstetrics and Gynecology-Perinatal Grand Rounds	02/05/2007	1.00
Obstetrics and Gynecology-Grand Rounds	02/08/2007	1.00
Obstetrics and Gynecology-Grand Rounds	02/15/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	02/19/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	02/26/2007	1.00
Obstetrics and Gynecology-Grand Rounds	03/01/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	03/05/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	03/12/2007	1.00
Obstetrics and Gynecology-Grand Rounds	03/15/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	03/26/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	04/02/2007	1.00
Obstetrics and Gynecology-Grand Rounds	04/05/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	04/09/2007	1.00
Obstetrics and Gynecology-Perinatal Grand Rounds	04/12/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	04/23/2007	1.00
Obstetrics and Gynecology-Grand Rounds	04/26/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	04/30/2007	1.00
Obstetrics and Gynecology-Grand Rounds	05/03/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	05/21/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	06/11/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	06/18/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	06/25/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	07/09/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	07/16/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	07/30/2007	1.00

University of Michigan
Medical School

CME Report for Continuing Medical Education Programs Attended During 2007

This report documents AMA PRA Category 1 credit earned for programs that took place at the University of Michigan Health System for which an orange attendance/evaluation card was submitted before 12/31/2007. THIS COPY IS FOR YOUR RECORDS. Documentation of this credit is also on file in the Department of Medical Education. Questions should be directed to Tana DeClercq, CME Credit Coordinator, at (734) 936-1664 or tdeclerc@umich.edu.

Participant Name: **Willie Parker, MD, MPH**

Department - Program Name	Program Date	Credit
Obstetrics and Gynecology-Morbidity and Mortality Conference	08/13/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	08/20/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	08/27/2007	1.00
Obstetrics and Gynecology-Morbidity and Mortality Conference	09/10/2007	1.00
Obstetrics and Gynecology-Grand Rounds	09/13/2007	1.00

Total Credit Hours for Willie Parker, MD, MPH **35.00**

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

Licensing Program
1426 Howe Avenue #54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2944
www.mbc.ca.gov

August 20, 2007

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, 2007
STATUS:	RENEWED/CURRENT
BOARD DISCIPLINE:	No

This license information was last updated on: 08/20/2007

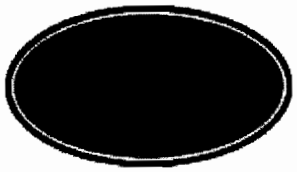
Further public records pertaining to the above licensee may be available from the Board's Web site at www.mbc.ca.gov.

Gary Qualset

GARY QUALSET, CHIEF
DIVISION OF LICENSING

Grubb, Penny

From: support@veridoc.org
Sent: Monday, August 20, 2007 10:54 PM
To: Med License
Subject: License Verification Statement
Attachments: v12070AA.pdf



Verification of Licensure Status

The attached verification report has been sent to you by the VeriDoc.org website. This email can be verified as coming from this site by clicking on the link below.

Validate Verifications

Transaction ID: 12070

Confirmation Number: 88227381592391552491

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

08/27/07

STATE MEDICAL BOARD OF OHIO
77 S HIGH ST - 17TH FLOOR
COLUMBUS OH 43215 6127

RE: VERIFICATION OF LICENSE/EXAM SCORES DATED 08/27/07 FOR
WILLIE PARKER

BOARD/COMMISSION:	BOARD OF MEDICAL EXAMINERS
LICENSE TYPE:	PHYSICIAN
LICENSE IDENTIFICATION:	MD 11733
METHOD OF LICENSURE:	PASSED FLEX
DATE LICENSED:	10/11/01
LICENSE STATUS:	CURRENT, VALID & IN GOOD STANDING
LICENSE EXPIRATION DATE:	01/31/08
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 A. Cabral

CONSTANCE CABRAL
EXECUTIVE OFFICER

call

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

LICENSE RESTORATION - MEDICINE OR OSTEOPATHIC MEDICINE
FORM 2 - VERIFICATION OF LICENSE

I am applying for restoration of my license to practice medicine or osteopathic medicine in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio.

TO BE COMPLETED BY APPLICANT

Name	Last: Parker	First: Willie	Middle: J	Suffix (Jr., II):	
Current Address	Number & Street: 635 Liberty Pointe Drive			License Number:	11733
	City: Ann Arbor	State: MI	Zip: 48103	Date of Birth:	Month/Day/Year: 10/18/62
Medical/Osteopathic School of Graduation	University of Iowa				

I hereby authorize the licensing agency of the State of HAWAII to furnish the information below to the State Medical Board of Ohio.

Signature of Applicant	Parker MD, MPH	Date	8/20/07

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State					
Name of Licensee	Last	First	Middle	Suffix (Jr., II)	
License Number		Issue Date	month/day/year / /	License current? If not, please explain	☐ Yes ☐ No

	Yes	No	Cannot answer under current state law
Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?	☐	☐	☐
Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?	☐	☐	☐
Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?	☐	☐	☐

If yes, please attach complete details.

AFFIX BOARD SEAL NOT VALID WITHOUT SEAL

Signature

Title

Date

RETURN COMPLETED FORM TO THE STATE MEDICAL BOARD OF OHIO AT THE ABOVE ADDRESS.

STATE MEDICAL BOARD OF OHIO
77 S HIGH ST - 17TH FLOOR
COLUMBUS OH 43215-6127

THIS IS AN ADDRESS PAGE

STATE OF MICHIGAN

JENNIFER M. GRANHOLM
GOVERNOR

DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

VERIFICATION OF LICENSURE

OHIO STATE MEDICAL BOARD

SEP 21 2007

RECEIVED

MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 09/14/2007

STATE MEDICAL BOARD OF OHIO
77 S HIGH ST 17TH FLR
COLUMBUS OH 43215-6127

NAME:	Willie James Parker	**SSN:**	Redacted
ADDRESS:	635 Liberty Pointe Dr Ann Arbor MI 48103	**BIRTHDATE:**	10/18/1962

TYPE:	Medical Doctor			**ORIGINAL DATE:**	05/08/2006
LICENSE NUMBER:	4301087686	**STATUS:**	Active	**EXPIRATION DATE:**	01/31/2010
OBTAINED BY:	Endorsement				

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

Jane Noel

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

IOWA BOARD OF MEDICINE
ANN E. MOWERY, Ph.D., EXECUTIVE DIRECTOR

August 29, 2007

Ohio State Medical Board
30 E. Broad Street 3rd Floor
Columbus, OH 43215-6127

This serves as official verification that the physician listed below has a license to practice in the state of Iowa.

PHYSICIAN:	Parker, Willie James
DATE OF BIRTH:	October 18, 1962
SSN:	Redacted
LICENSE NUMBER:	28574
LICENSE TYPE:	M.D.
HOW OBTAINED:	FLEX IA
DATE ISSUED:	March 19, 1992
EXPIRATION DATE:	October 1, 1994
STATUS:	Inactive
DISCIPLINARY ACTION:	No

The above format is the standard format prepared for all physicians regulated by this board. All physicians are considered in good standing unless otherwise noted. If formal action has been indicated then a copy of that certified information has been attached.

Sincerely,

Sylvia H. Crook
Licensing Specialist
Iowa Board of Medicine

OHIO STATE MEDICAL BOARD

SEP 04 2007

RECEIVED

400 SW 8th STREET, SUITE C, DES MOINES, IA 50309-4686
PHONE:515-281-5171 FAX:515-242-5908 http://www.medicalboard.iowa.gov

State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

OHIO STATE MEDICAL BOARD

SEP 04 2007

PAID

RECEIVED

LICENSE RESTORATION - MEDICINE OR OSTEOPATHIC MEDICINE
FORM 2 - VERIFICATION OF LICENSE

I am applying for restoration of my license to practice medicine or osteopathic medicine in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by each state or Canadian province in which I hold or have held licenses, whether now current or not. Please complete the form and return it directly to the State Medical Board of Ohio.

TO BE COMPLETED BY APPLICANT

Name	Last: Parker	First: Willie	Middle: J	Suffix (Jr., II):	
Current Address	Number & Street: 635 Liberty Pointe Drive			License Number:	
	City: Ann Arbor	State: MI	Zip: 48103	Date of Birth: Month/Day/Year: 10/18/62	
Medical/Osteopathic School of Graduation	University of Iowa				

I hereby authorize the licensing agency of the State of Iowa to furnish the information below to the State Medical Board of Ohio.

Signature of Applicant	[signature]
Date	8/20/07

TO BE COMPLETED BY STATE BOARD OR CANADIAN PROVINCE

State					
Name of Licensee	Last	First	Middle	Suffix (Jr., II)	
License Number		Issue Date	month/day/year / /	License current? If not, please explain	☐ Yes ☐ No

	Yes	No	Cannot answer under current state law
Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state?	☐	☐	☐
Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state?	☐	☐	☐
Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?	☐	☐	☐

If yes, please attach complete details.

AFFIX BOARD SEAL NOT VALID WITHOUT SEAL

Signature

Title

Date

RETURN COMPLETED FORM TO THE STATE MEDICAL BOARD OF OHIO AT THE ABOVE ADDRESS.

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

OHIO STATE MEDICAL BOARD
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THIS FORM MUST BE COMPLETED BY A SUPERVISOR OR THE CHIEF OF STAFF

University of Michigan
Department of Obstetrics/Gynecology

PLEASE COMPLETE AND FAX TO (614) 644-1464 THEN MAIL ORIGINAL.

August 28, 2007

Willie James Parker, M.D., who is/was Fellow-OB/GYN , is applying to restore his/her Ohio license, which expired in 1996. We would appreciate your assistance in filling out the following evaluation, so that we can process his/her documents for restoration. Dr. Parker stated on his/her restoration application that he/she was affiliated with your organization 06/06/ to present.

(1) How long have you known the doctor? 1 1/2 years

(2) What is your capacity at the facility? CHAIR, OB/Gyn

(3) At what facility? University of Michigan

(4) How would you rate this doctor's medical knowledge & techniques? GOOD, COMPETENT

(5) In your opinion, is this doctor a person of good moral & ethical character? Yes

(6) Does this doctor work well with peers and medical staff? Yes

(7) Does this doctor relate well to patients? Yes

(8) Would you recommend this doctor's license be restored? Yes

Please indicate any information of a derogatory nature: - NONE - RECOMMEND WITH CONFIDENCE -

THIS FORM MUST BE COMPLETED BY A SUPERVISING PHYSICIAN

Signature of Person Completing Form

Name of Person Completing Form
(please print or type)
T. Murray R.B. Johnson, MD

Position
Professor + Chair, OB/Gyn

734-764-8123
Telephone number (include area code)

Please return this form to the Ohio State Medical Board at the above address, Attn: Peri Vest

Sincerely,

Peri E. Vest

Peri E. Vest
Licensure/CME Renewal Assistant
State Medical Board of Ohio

Vest, Peri

From: Willie Parker [berean86wp@yahoo.com]
Sent: Monday, September 24, 2007 08:56 AM
To: Vest, Peri
Subject: Fwd: Re: Greetings for Willie Parker....request assistance

Ms. Vest-

The following timeline indicates my practice activities for the past 10 years, related to requests verification of claim actions. I submit this to indicate and confirm from whom I need to obtain statements. I submitted the only two incidents where I have been named in a suit.

1997-2001- Attended public health school and work for the Centers for Disease control as a medical epidemiologist. No malpractic coverage and clinical practice.

2002-2006-Queens Medical Center- verifiable by email below. As you can note from the forwarded email, they asked that I have you request directly, and they will copy me. I do not have a form to send to them, and I am surprised that the note from you that I forwarded did not suffice. Can you send the email request to Mr. Kahaulelio as requested, or inform me how to proceed?

2006-present. I will request that Jane Juckno from the University of Michigan send you a note or have someone from risk management send a note. OK

Thank you for all of your attention. I don't know if all that you have done for me falls under your routine scope of duties, but you have made me feel like you have gone the extra mile for me at every turn, facilitating this process, and for that I am greatly appreciative. Once this is done, I would like to write a letter of appreciation to whomever appropriate about you high degree of professionalism in carrying out your duties. Thank you very much.

Willie J. Parker, MD

DAVID KAHAULELIO <DKAHAULELIO@queens.org> wrote:

> Date: Fri, 21 Sep 2007 07:45:37 -1000
> From: "DAVID KAHAULELIO" <DKAHAULELIO@queens.org>
> To: "BOB HEE" <BHEE@queens.org>,
> berean86wp@yahoo.com
> CC: "Judy KUSAKA" <JKUSAKA@queens.org>
> Subject: Re: Greetings for Willie Parker....reques assistance
>
> Aloha,
>
> We can provide the verification required for Willie's employment at
> Queen's.
>
> Bob,
> Please confirm the employment period.

Regards,
Willie Parker

"Vest, Peri" wrote:
Subject: RE: State Medical Board of Ohio
Date: Thu, 20 Sep 2007 10:49:24 -0400
From: "Vest, Peri"
To: "Willie Parker"

I just went over your application again and other than the MI verification missing, I do not have your claims history for the last 10 years. Have you requested it from your malpractice insurance carrier(s)? They can fax it to me at (614) 644-1464.

From: Willie Parker [mailto:berean86wp@yahoo.com]
Sent: Wednesday, September 19, 2007 12:32 PM
To: Vest, Peri
Subject: RE: State Medical Board of Ohio

Ms. Vest: I did send those documents on yesterday. I am gladly re-sending those cme's. Thanks again for all of your help. Please confirm receipt.

Willie Parker

"Vest, Peri" wrote:
Dr. Parker-

Did you e-mail me copies of your CME? If you did, I cannot find them anywhere. Could you please re-send? I am sorry for the inconvenience.

Peri

From: Willie Parker [mailto:berean86wp@yahoo.com]
Sent: Monday, September 17, 2007 12:13 PM
To: Vest, Peri
Subject: Re: State Medical Board of Ohio

Ms. Vest:
Thank you very much for your attentiveness and facilitation of my application. I will contact MI and Hawaii re: the verification. Am I allowed to send CME from the past academic year? Also, would my ABOG recertification credits for 2006 count? Thanks again for your help.

Regards,
Willie Parker

"Vest, Peri" wrote:
Hi Dr. Parker,

I just wanted to give you an update on your Ohio restoration application. Here are the items that are missing from your application.

1) We have not received the Form I's (license verification) from the states of Michigan and Hawaii.

2) Although you have sufficient Continuing Medical Education I credits for the period requested (62.5), we require a total of 100 CME credits for license restoration. I have attached a form to this e-mail. Please complete with any CME II credits that you have. CME II credits are any reading or self-instruction that you have completed during the period requested. 1 hour reading or self-instruction =1 hour credit. It does not need to be specific. You can then fax this form to (614) 644-1464.

I have e-mailed you because it is so much faster to communicate. If you would prefer a formal letter, please let me know. Also let me know if you have any questions or problems.

Sincerely,

Peri Vest
Licensure/CME Renewal Assistant

THIS FORM MUST BE COMPLETED BY A SUPERVISOR OR THE CHIEF OF STAFF

Queens Medical Center
Department of Obstetrics/Gynecology

PLEASE COMPLETE AND FAX TO (614) 644-1464 THEN MAIL ORIGINAL.

September 24, 2007

Willie James Parker, M.D., who is/was Assistant Professor/OB-GYN, is applying to restore his/her Ohio license, which expired in 1996. We would appreciate your assistance in filling out the following evaluation, so that we can process his/her documents for restoration. Dr. Parker stated on his/her restoration application that he/she was affiliated with your organization 01/02 to 06/06.

(1) How long have you known the doctor? 5 years

(2) What is your capacity at the facility? chief, dept OBGYN

(3) At what facility? Queen's med center

(4) How would you rate this doctor's medical knowledge & techniques? superior

(5) In your opinion, is this doctor a person of good moral & ethical character? yes

(6) Does this doctor work well with peers and medical staff? yes

(7) Does this doctor relate well to patients? yes

(8) Would you recommend this doctor's license be restored? yes

Please indicate any information of a derogatory nature: None

THIS FORM MUST BE COMPLETED BY A SUPERVISING PHYSICIAN

Signature of Person Completing Form
Name of Person Completing Form
(please print or type)

Position chief, OBGYN

Queen's med center

Telephone number (include area code)

NATHAN G. FUJITA, M.D.
1329 Lusitana St., Suite 402
Honolulu, HI 96813
Phone (808) 538-3787

Please return this form to the Ohio State Medical Board at the above address, Attn: Peri Vest

Sincerely,

Peri E. Vest
Licensure/CME Renewal Assistant
State Medical Board of Ohio

Do not complete if the lawsuit/NOI is from a case at University of Michigan

* Malpractice Explanation for lawsuits and Notices of Intent:

Name of Claimant: Heather Britton Date of Incident: Jan. 13, 1995

Date lawsuit/NOI filed: January 1996

If lawsuit: Court: California Municipal Court
Title of Case: Heather Britton v. Willie Parker MD
Case #: _____

* What was your status?

☐ Sole Defendant ☑ Co-Defendant with Golden Valley Health Center
☐ Other _____ Merced Community Medical Ctr.

* Nature of Allegations:

Initial Allegation of medical negligence and mal-practice unsupportable by expert testimony, changed to lack of informed consent. Laparoscopy complicated by cystotomy with failed healing by secondary intent requiring laparotomy and primary closure

* Outcome/current status of patient's medical condition:

no long term sequelae, subsequent normal pregnancy. Pt settled with clinic and hospital for $30,000, after I (primary defendant) was dismissed from the case with prejudice.

---

* Status of Case (Please attach any related documents)

☐ Pending

☑ Dismissed from case without payment
Date April ~~1996~~ 1997

☐ Verdict for defendant
Date _____

☐ Pre-trial Settlement $ _____ Date _____

☐ Verdict for plaintiff $ _____ Date _____

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LAWSUITS or NOTICES OF INTENT

Do not complete if the lawsuit/NOI is <u>from</u> a case at University of Michigan

❋ Malpractice Explanation for lawsuits and Notices of Intent:

Name of Claimant: Gerla + Mathew Moniz Date of Incident: 11/3/2003

Date lawsuit/NOI filed: 8/2005

If lawsuit: Court: HI Civil Court
Title of Case: Gerla + Mathew Moniz vs QMC, W. Parker,
Case #: No. 06-1-1881-10 (BIA) MK.

❋ What was your status?

- ☐ Sole Defendant ☑ Co-Defendant with Queens Medical Ctr, M. Hiramoto
- ☐ Other _____

❋ Nature of Allegations:

Allege that Dr. Parker + others failed to adequately supervise resident training staff in mgt of early pregancy diagnosed as a loss with subsequent information conflicting with previous report.

❋ Outcome/current status of patient's medical condition:

First motions filed July 2007. Discovery phase of trial pending

---

❋ Status of Case (Please attach any related documents)

OHIO STATE MEDICAL BOARD

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- ☑ Pending
- ☐ Dismissed from case without payment
  Date _____
- ☐ Verdict for defendant
  Date _____
- ☐ Pre-trial Settlement $ _____ Date _____
- ☐ Verdict for plaintiff $ _____ Date _____