STATE OF MARYLAND

DHMH Board of Physicians

Maryland Department of Health and Mental Hygiene
4201 Patterson Avenue • Baltimore, Maryland 21215-2299
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

July 15, 2009

Willie James Parker, M.D.
[redacted]

Re: Initial Medical License

Dear Dr. Parker:

The Board of Physicians (the Board) is pleased to inform you, the processing of your application for a medical license in the State of Maryland is now complete. You have been issued license number D0069574 effective from July 15, 2009 to September 30, 2009.

You will receive a refund in the amount of $420.00 in approximately eight to ten weeks. The refund will come from the Comptroller's Office in Annapolis, Maryland and be made payable to you. If someone, other than you, paid the initial application fee, it is your responsibility to reconcile the refund with the other party.

Please be advised, you must renew your medical license before the date it expires. Pursuant to regulations effective since April 5, 1999, you are required to complete the Maryland Board of Physician's New Physician Orientation Program prior to your first renewal of your Maryland medical license. Your renewal will not be processed until you have completed the orientation program. You may complete this program by visiting http://www.mbp.state.md.us, on the Internet and clicking on the button for the New Physician Orientation Program. Be sure to enter your license number and follow the prompts.

An individual with a non-renewed license is not authorized to practice medicine in Maryland. Any person who practices medicine in Maryland without a license is subject to a civil fine of not more than $50,000.00 to be levied by the Board (Md Code Ann., Health Occ. §§ 14-601, 606).

You must also notify the Board in writing of any change in name or address within 60 days of the change. Failure to do so may subject you to an administrative penalty of $100.00 (Md Code Ann., Health Occ. §14-316 (f)).

Enclosed are the following: a registration card that reflects your license number and its expiration date; a wall certificate; and a packet of information for you as a newly licensed physician in Maryland.

Thank you for selecting Maryland as your practice site.

Sincerely,

Carol B. Johnson

Carol Johnson
Licensure Analyst

Initial Medical Licensure
PERSONAL INFORMATION
06/2008 INT

105044

STOP! Completed application and check must be mailed to:
MARYLAND BOARD OF PHYSICIANS
P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 Fax: 410-358-1298 Toll Free: 800-492-6836

FOR BANK USE ONLY
Date
Check Number 2587
Amt Paid 837
Name Code
AppID 17

APPLICATION FOR INITIAL MEDICAL LICENSURE

Please print legibly or type the required information. Do not leave any item unanswered. If an item does not apply to you, write "N/A" (Not Applicable) for that item. An incomplete application form will delay the processing of your application.

1. **Your Complete Current Legal Name:** As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.
Last name and generational indicator (Jr., Sr., II, III, etc.): PARKER
First name and middle name: WILLIE JAMES
(If applicable, please check a box and complete below) ? Complete Maiden Name OR ? Complete Former Name

Stop! If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.

2. **Public Address:** Your public address of record. This address, usually your office, is available to the public and will be posted on the internet.
Street Address: If you change your address prior to being licensed, immediately notify the Board in writing.
[redacted]
City State Zip Code

3. **Non-Public Address:** This address, usually your home, is for Board use only. However, if no public address is listed, this address will be made public.
Street Address: (Do NOT use a P. O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.
[redacted]
City State Zip Code

4. **Telephone (s):** Home [redacted]
Office: 301-608-3448
Cell/Pager: - -
E-mail address: Bereana86wp@yahoo.com

5. **Date of Birth:** Month Day Year [redacted]

6. **Gender:** ☒ Male ☐ Female

7. **Race:** Multiracial applicants may select all applicable categories ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

8. **Social Security Number:** [redacted]

RECEIVED
NOV - 2
BOARD OF PHYSICIANS

For Board Use Only

License Number: D69574 BPQA School Code: 01 18 003
Date Issued: 07 15 09 Federation School Code: 01 6 010
Licensed By: Carol Bohm Licensing Exam: FLEX

Initial Medical Licensure
CHRONOLOGY
06/2008 INT

Print Your Name: Willie James Parker Date 5/09/09

9. **Chronology of Activities: DO NOT ATTACH RESUME OR CURRICULUM VITAE**

Beginning with the date you completed medical school and continuing through the present, list chronologically all of your activities. Account for all periods of time including each post-graduate training program you attended, regardless of whether or not you completed the program; each job you held, regardless of whether or not it was medically related or you were compensated; and any period of unemployment.

Date Medical School was Completed:	month	year
	05	90

Activities after completing medical school: Please type or print.

month	year	TO	month	year	Activity:
07	96	TO	06	94	Residency Training - OB-Gyn- University of Cincinnati

Address: Medical Sciences Building, Room 6255A
231 Albert Sabin Way PO Box 670525
Cincinnati, OH 45267-0525

month	year	TO	month	year	Activity:
07	94	TO	06	97	Staff Physician Golden Valley Mea/Hth Center

Address: 737 W. Childs Avenue
Merced, CA 95340

month	year	TO	month	year	Activity:
07	97	TO	06	98	Masters Program (School) Harvard School Public Health

Address: Registrar's Office
677 Huntington Ave, Kresge 64 Boston MA 02115

month	year	TO	month	year	Activity:
07	98	TO	06	00	Medical Epidemiology, Centers for Disease Control

Address: Centers For Disease Control, EPO
600 Clifton Road Atlanta, GA 30333

month	year	TO	month	year	Activity:
07	00	TO	12	01	Public Health Physician CA Dept of Health Services

Address: Dr. Gilberto Chavez
CA Dept Health Services PO Box 997413 MS 7300
Sacramento, CA 95899-7413

month	year	TO	month	year	Activity:
01	02	TO	06	06	Physician Queens Medical Center

Address: Attn.: Bob Hee 1301 Punchbowl Street
Honolulu, HI 96813

month	year	TO	month	year	Activity:
07	06	TO	06	08	Clinical Professor/Fellow, Univ. of Michigan ✓

Address: 1500 East Medical Center Drive, L4000
Ann Arbor, MI 48109-0276

month	year	TO	month	year	Activity:
08	08	TO	05	09	Director/Physician Washington Hospital Ctr

Address:
110 Irving Street, NW, Room 5B-63 Washington DC 20010

CONTINUED ON PAGE 3: If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.

Initial Medical Licensure
CHRONOLOGY
06/2008 INT

Print Your Name: Willie J. Parker Date: 5/09/09

Chronology (Cont'd) Please photocopy this page if more space is needed. Sign and date all additional pages.

month year TO month year Activity: See page 2

Address:

month year TO month year Activity:

Address:

month year TO month year Activity:

Address:

month year month year Activity:

WILLIE J PARKER
[redacted]

2583

5/9/09
Date

Pay to the Order of Maryland Board of Physicians $ 822.00

eight hundred twenty two & 00/100 Dollars

USAA FEDERAL SAVINGS BANK
10750 McDERMOTT FWY
SAN ANTONIO, TEXAS 78288-0544
(210) 498-2265 1-800-531-USAA

Make a Difference

For licensure

Parker MD

[redacted]

Lockbox: 37217
Date: 05/29/2009
Batch: 23
Item: 1
Amount: $822.00
With "For Office Use Only" box

SUNTRUST

month year TO month year Activity:

Address:

month year TO month year Activity:

Address:

MARYLAND BOARD OF PHYSICIANS
RECEIVED
2009 JUN -2 PM 8:56

Initial Medical Licensure
MEDICAL EDUCATION
09/2006 INT

Print Your Name: Willie J. Parker, MD, MP Date: 5/9/09

10. **MEDICAL EDUCATION: List all medical schools you have attended**

	From: MM/YY To MM/YY
University of Iowa	06/86 05/90

Medical School From Which You Received Your Medical Degree: University of Iowa

Name of University Affiliation (if applicable): * University of Iowa

Street Address: CMAB

City: Iowa City **State/Province:** IA **Country of citizenship during medical education:** USA

Language(s) of Instruction: English

Type of Degree: ☒ M.D. ☐ D.O. ☐ M.D./Ph.D ☐ M.B.B.S. ☐ M.B.B.Ch ☐ Other:_____ (specify)

Date Degree Was Conferred: The date you officially received your degree after all prerequisite obligations, required training, government service, etc. was satisfied.

Month 05 Day 04 Year 90

GRADUATES OF FOREIGN MEDICAL SCHOOLS (Schools not in the U.S. or its territories, Puerto Rico, or Canada)
Attach the following documents to this application:

1) **A copy of your valid ECFMG certificate or Fifth Pathway Certificate;**

2) **A copy of your medical school diploma and a certified translation;**

3) **If you listed an affiliation above (see * in 10 above), attach a copy of the Certificate of Medical Education and Examinations Taken, Good Conduct Certificate or Intern Certificate. The certificate must include your name, name of the medical school, name of the university, and a certified translation .**

If your name is not written the same way on all documents, you must submit documentation to explain how and why your name differs and submit one of the following documents to support the name change; Passport, INS card, birth certificate, court document, marriage license, court decree.

11. **How have you satisfied Maryland's *written and oral* English language competency requirements?**
(See *English Language Competency Requirements for Medical Licensure in Maryland* in the introductory material included with your application.)

a. ☑ I graduated from a medical school or, after at least three years of attendance, a high school (includes GED), undergraduate college, or university where English was the *only* language of instruction throughout (you must provide documentation); or

b. ☐ I passed either ☐ the TOEFL or ☐ the ECFMG English test after December 31, 1973 **AND** I passed the ☐ TSE or ☐ OPI. If you have taken the Test of English as a Foreign Language (TOEFL) and either the Test of Spoken English (TSE) or the Oral Proficiency Interview (OPI), please request that Education Testing Service and/or Language Testing International send verification of your scores directly to the Board;

c. ☐ I passed the USMLE Step 2 Clinical Skills Exam.

Are you claiming speech impairment? ☒ NO ☐ YES If "YES," please write or call the Board for additional information.

Print Your Name: Willie J. Parker, MD, MPH Date: 5/9/09

12. POSTGRADUATE TRAINING (DO NOT ATTACH RESUME OR CURRICULUM VITAE.) List in chronological order ALL postgraduate training undertaken in the United States, its territories or possessions, Puerto Rico, or Canada regardless of whether you did or did not complete the program, and regardless of whether you were or were not compensated. (Copies of training certificates are helpful, but not required.)

NOTE: On a case by case basis, the Board may consider full time teaching in an LCME accredited medical school in the United States as an alternative to the accredited postgraduate clinical medical education required in the Code of Maryland Regulations 10.32.01.03D. Applicants who intend to request consideration of teaching experience as an alternative to accredited postgraduate clinical medical education should contact the Board's licensure division for further information.

Effective October 1, 2000, graduates of all medical schools NOT in the U.S., its territories or possessions, Puerto Rico, or Canada are required to submit evidence acceptable to the Board of successful completion of 2 years of training in a postgraduate clinical medical education program accredited by an accrediting organization recognized by the Board (ACGME, AOA, or equivalent). If you have not met this requirement, DO NOT submit this application.

A Fifth Pathway Program graduate must have been a U.S. citizen during the time of medical education and must have successfully completed two years of ACGME accredited postgraduate clinical medical education *after* successfully completing a Board approved Fifth Pathway program. If you have not met these two critera, DO NOT SUBMIT THIS APPLICATION.

If after 10/1/92 you passed any medical licensing exam (or part, step, or component thereof) that you failed three times, either before or after 10/1/92, then you must successfully complete another year of ACGME/AOA accredited clinical postgraduate training in addition to the year(s) usually required by Maryland. All of the additional year must have begun after the date of the last fail. Teaching will not be accepted as an alternative to a year required following three or more fails. If you have not met this requirement, DO NOT submit this application. If you failed any part, step, or component of a medical exam four times, DO NOT SUBMIT THIS APPLICATION; you are not eligible for medical licensure in Maryland.

NOTE: Postgraduate training program cycles usually run from July 1 to June 30. If the dates of your postgraduate training are not within the usual cycle, fall short of the complete cycle, or extend beyond the usual cycle, please attach a complete explanation of why your training was "off-cycle."

PG Year #s: 4	Place of Training: University of Cincinnati	Address:	Specialty: OB-Gyn	month: 07 year: 90 TO month: 06 year: 94 ✓ Accredited by: ACGME ☑ AOA ☐ RCPSC ☐
PG Year #s: 2	Place of Training: University of Michigan	Address: 1500 E. Medical Center Dr. 4000 Ann Arbor, MI 48109	Specialty: Family Planning	month: 07 year: 96 TO month: 06 year: 98 ✓ Accredited by: ACGME ☐ AOA ☐ RCPSC ☐
PG Year #s:	Place of Training:	Address:	Specialty:	month: year: TO month: year: Accredited by: ACGME ☐ AOA ☐ RCPSC ☐
PG Year #s:	Place of Training:	Address:	Specialty:	month: year: TO month: year: Accredited by: ACGME ☐ AOA ☐ RCPSC ☐
PG Year #s:	Place of Training:	Address:	Specialty:	month: year: TO month: year: Accredited by: ACGME ☐ AOA ☐ RCPSC ☐

(ATTACH A SEPARATE SIGNED AND DATED PAGE IF ADDITIONAL SPACE IS NEEDED)

Initial Medical Licensure HOSPITAL PRIVILEGES 09/2008 INT	Print Your Name: Willie James Parker	Date: 05/09/09	Page 6 of 11

13. **Hospital Privileges After Postgraduate Training:** Please list all hospitals where you have had privileges or have provided services after the completion of your postgraduate training for the five year period preceding the filing of this application. Copy this page if more space is needed and enclose each signed and dated addition.

Hospital:	month / year TO month / year
Washington Hospital Center	08 08 TO 05 09
Complete Address:	Department
110 Irving Street, NW Washington, DC 20010	OB-Gyn
Hospital:	month / year TO month / year
University of Michigan Health Systems	07 06 TO 06 08
Complete Address:	Department
1500 E. Medical Center Drive Ann Arbor MI 48109	OB-Gyn
Hospital:	month / year TO month / year
Queens Medical Center	01 02 TO 05 06
Complete Address:	Department
1301 Punchbowl Street, Honolulu, HI 96813	OB-Gyn
Hospital:	month / year TO month / year
Complete Address:	Department
Hospital:	month / year TO month / year
Complete Address:	Department
Hospital:	month / year TO month / year
Complete Address:	Department
Hospital:	month / year TO month / year
Complete Address:	Department
Hospital:	month / year TO month / year
Complete Address:	Department
Hospital:	month / year TO month / year
Complete Address:	Department
Hospital:	month / year TO month / year
Complete Address:	Department

Initial Medical Licensure
MEDICAL EXAMS
08/2008 INT

Print Your Name: Willie James Parker Date: 5/09/09

14. **Medical Licensing Examinations** (USMLE, NBME, NBOME, FLEX, FLEX-Weighted Average, Medical Council of Canada, and licensing exams given by individual states prior to January 1, 1985) **DO NOT SUBMIT THIS APPLICATION until you have received written verification of having passed all parts, steps, or components of your medical licensing examinations.**

Identify below ALL the medical licensing examinations that you have ever taken. Ask the administering authority of each exam to send the complete medical licensing examination history and scores directly to this Board. In each examination category below, you will find information to help you contact the administering authority.

a. Have you ever failed any medical licensing examination (or part, step, or component thereof)? NO ☒ YES ☐

b. Have you failed any medical licensing examination (or part, step, or component thereof) three or more times? NO ☒ YES ☐

If you answered "Yes" to a. and b., you must have successfully completed another year of ACGME-accredited clinical postgraduate training, in addition to the year(s) of training usually required for licensure in Maryland. No part of the additional year may have been taken before the date of the last fail. If you have not met this requirement, you are not eligible for licensure in Maryland at this time. DO NOT submit this application until you have fulfilled this requirement.

IF YOU HAVE FAILED ANY PART, STEP, COMPONENT OR APPROVED EXAMINATION COMBINATION MORETHAN 3 TIMES, You may not be eligible for medical licensure in Maryland. For a complete explanation see COMAR 10.32.01.03 Licensure--Qualifications for Initial Licensure

a. **State Board Examination** List state(s): _____

STATE BOARD DOES NOT INCLUDE STEP 3 OF USMLE, ORAL EXAMS, OR INTERVIEWS. State Board Examinations were licensing exams given by individual states. State Board Examinations taken after December 31, 1984 are not accepted for licensure in Maryland.

Send a copy of MBP IML7, *State Board Licensure and Examination Certification,* form to the state(s) which administered your licensing exam and ask the state(s) to send your exam results directly to the Maryland Board of Physicians. Also send a copy to each state that has ever issued you a license.

NOTE: Many states charge a fee for exam transcripts. Contact each state board prior to sending form IML7, as all fees are the responsibility of the applicant.

Federation of State Medical Boards (See Page 8 if you took a combination of these exams or combined either with the NBME exams)

b. ☒ **FLEX-Weighted Average: All FLEX-Weighted exams prior to 1985 must have been taken in one sitting (3 consecutive days). Flex weighted average exams taken in more than one sitting must have current ABMS or AOA Board Certification unless you are currently certified by a member board of the American Board of Medical Specialties.**

c. ☐ FLEX Components 1 and 2: **Examinations must be passed within 5 years of each other.**

d. ☐ USMLE Steps 1, 2, and 3: **Passing scores on all parts must have been completed within a 10-year period beginning with the month and year when the applicant first passed either step 1 or step 2.**

If you took any of the above examinations you must ask the Federation of State Medical Boards (FSMB) to send your transcripts to the Board by accessing their website at www.fsmb.org. *Click transcript requests.*

e. ☐ **National Board of Medical Examiners** (See Page 8 if you combined this examination with FLEX or USMLE exams)

If you have received NBME certification, ask NBME to send to the Board both the Endorsement of Certification *and* the Record of Scores. All requests must be made through the NBME website at http://www.nbme.org or call 215-590-9592. If you took NBME exams but were not certified, or you took NBME as part of hybrid exams, ask NBME to send only your Record of Scores.

f. ☐ **National Board of Osteopathic Medical Examiners Certifications issued before January 1, 1971 are not accepted for licensure in Maryland.** If you have received NBOME certification, ask NBOME to send to this Board the verification of certification and the complete history of your medical examinations. Contact NBOME at 773-714-0622 for instructions and fee information.

g. ☐ **Medical Council of Canada**

Licentiate of the Medical Council of Canada

Please request that verification of your Licenciate Certification and a complete LMCC examination history be sent directly to this Board. Call MCC at 613-521-6012 for instructions and fee information.

CONTINUED ON PAGE 8

HYBRID EXAMINATIONS

The following combinations are the only hybrid examinations accepted by the Maryland Board.

Passing scores on all parts of hybrid examinations must have been completed within a 10-year period, beginning with the month and year the examinee first passes a part or component or step of the combined examination. ALL HYBRID EXAMINATIONS MUST HAVE BEEN COMPLETED BEFORE JANUARY 1, 2000.

h. ☐ USMLE 1 + NBME II + NBME III

i. ☐ USMLE 1 + USMLE 2 + NBME III

j. ☐ USMLE 1 + NBME II + USMLE 3

k. ☐ NBME I + USMLE 2 + USMLE 3

l. ☐ NBME I + USMLE 2 + NBME III

m. ☐ NBME I + NBME II + USMLE 3

n. ☐ FLEX 1 + USMLE 3

o. ☐ FLEX 2 + USMLE 1 + NBME II

p. ☐ FLEX 2 + USMLE 1 + USMLE 2

q. ☐ FLEX 2 + NBME I + USMLE 2

r. ☐ FLEX 2 + NBME I + NBME II

- If your hybrid exams included any part of the NBME examination, contact NBME at http://www.nbme.org or call 215-590-9592 for instructions and request that your Endorsement of Certification *and* your Record of Scores be sent directly to the Maryland Board of Physicians.
- If your hybrid exams included only FLEX and USMLE examinations, request your transcript from the Federation of State Medical Boards at www.fsmb.org.

15. Licensing History:

a. ☐ I have never been licensed in the U.S., its territories, or Puerto Rico and have never been licensed or registered in Canada.

b. ☐ I have an application for license pending in the following states: _____, _____, _____, _____, _____

c. Please list below all licenses ever issued to you by a U. S. state/territory or Puerto Rico. Also list all Canadian licenses and registrations.

d. Has any disciplinary action ever been taken against your license? ☑ No ☐ Yes If yes, please enclose an explanation.

STATE (Or Puerto Rico or Canadian Province)	LICENSE NUMBER or Registration Number	CURRENT STATUS					
		Active	Inactive	Expired/Lapsed	Surrendered in good standing	Surrendered / Suspended	Revoked
✓ Iowa	28574		X				
✓ OHIO	35.063458	X					
✓ California	A 53102	X					
✓ Hawaii	MD-11733	X					
✓ MICHIGAN	4301087686	X					
✓ DC	MD037446	X					

(If more space is needed, please attach an additional signed and dated sheet.)

Initial Medical Licensure
SPEX, Character/Fitness
08/2008 INT

Print Your Name: Willie James Parker Date: 05/05/09

16. Check YES or NO.

- [X] [X] Did you successfully complete a medical licensing exam (USMLE, NBME, etc.) within the 15-year period prior to filing this application?
- [X] [ ] During the past 10 years, have you maintained uninterrupted licensure since you were first issued a license in the United States, its territories, Puerto Rico, or Canada ?
- [X] [ ] Do you have lifetime certification from, or within the past 10 years have you been certified or recertified by, a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada?

If "YES," in which specialty were you certified? OB-Gyn Date certified 11/96 ✓

⇒ **If you have answered "NO" to all three of the above questions, you MUST take the Special Purpose Examination. After you submit this application, contact the Federation of State Medical Boards at 817-571-2949 and arrange to take the SPEX in Maryland, and have scores sent to the Maryland Board directly.**

17. **Character and Fitness Questions** (Check either YES or NO)

	YES	NO	
a.	[redacted]	[X]	Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, denied your application for licensure, reinstatement, or renewal?
b.			Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, taken action against your license? Such actions include, but are not limited to, limitations of practice, required education, admonishment, reprimand, suspension, or revocation. Refer to the document *Grounds for Board Action in Maryland* at the Board's website www.mbp.state.md.us.
c.			Has any licensing or disciplinary board in any jurisdiction (including Maryland), or a comparable body in the armed services, filed any complaints or charges against you or investigated you for any reason?
d.			Have you ever withdrawn your application for a medical license or other health professional license?
e.			Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?
f.			Has a hospital, related health care facility, HMO, or alternative health care system denied your application for, or failed to renew your privileges; or limited, restricted, suspended, or revoked your privileges in any way?
g.			Have you commited a criminal act to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgement?
h.			Have you committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgement? Such offenses include, but are not limited to, driving while under the influence of alcohol and/or controlled dangerous substances.
i.			Excluding minor traffic violations, are you currently under arrest or released on bond, or are there any current or pending charges against you in any court of law?
j.			Do you illegally use drugs?
k.			Do you have any physical or mental condition that currently impairs your ability to practice medicine or that would cause reasonable questions to be raised about your physical, mental, or professional competency?
l.			Have you ever been named as a defendant in a medical malpractice action?
m.			Are you in default of a service obligation that you incurred by receiving State or federal funds for your medical education?
n.			Have you failed to make arrangements to satisfy State or Federal loans that financed your medical education?
o.			Has your employment by any hospital, HMO, other health care facility or institution, or military entity been terminated for disciplinary reasons?
p.			Have you voluntarily resigned from any hospital, HMO, other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?
q.			Has the use of drugs and/or alcohol ever resulted in an impairment of your ability to practice your profession?
r.			Have you surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction or any entity of the armed services?

»» **If you answered "YES" to any of the questions in item 17, on the following page please list all adverse actions taken against you and provide a complete explanation. Attach any supporting documentation that applies (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgements or final orders). Sign and date all pages submitted.**

Initial Medical Licensure Character/Fitness Details 062008 INT

Print Your Name: Willie James Parker Date: 05/09/09

18 a. If you answered "YES" to any of the questions in item 17, please provide an explanation below and attach all complaints, pleadings and judgments. Attach additional signed and dated pages as needed.

18 b. If you answered yes to 17L - answer the following questions:

1. Total number of malpractice claims ever filed in which you were named as a defendant? 2

2. Total number of malpractice claims ever paid (settlement / judgment) in which you were named as a defendant? 0

3. Within the last 60 months (5 years) provide the following:
Total number of medical malpractice claims filed 1; paid (settlement / judgment) 0;
or dismissed 1; in which you were named as a defendant.

4. For a claim filed at any time, but paid (settlement / judgment) within the last 60 months (5 years), list each claim by claimants name; describe the disposition of each claim; and provide a copy of the complaint, pleading, and judgment of each medical malpractice claim.

defendant in operative laparoscopy

Initial Medical Licensure Release and Certification 06/2006 INT

RELEASE AND CERTIFICATION

19. Release:
I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for medical licensure in Maryland from any person or agency, including but not limited to postgraduate program directors, individual physicians, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, the Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

Willie James Parker — Applicant's Name (Printed)

Applicant's Signature

05/08/09 — Date

20. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: _____

Phone: _____

Applicant's Signature — Date

21. I agree that I will cooperate fully with any request for information or with any investigation related to my medical practice as a licensed physician in the State of Maryland, including the subpoena of documents or records or the inspection of my medical practice.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-404.

Parker, MD, MPH — Applicant's Signature

05/09/09 — Date

22. Affidavit: To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.

I certify that I have personally reviewed all the responses to items 1-22 of this application and that the information I have given is true and accurate to the best of my knowledge. I understand and agree that I may not practice, attempt to practice, or offer to practice medicine in Maryland unless licensed by the Board.

Parker, MD, MPH — Applicant's Signature

5/26/09 — Date

STATE OF DC

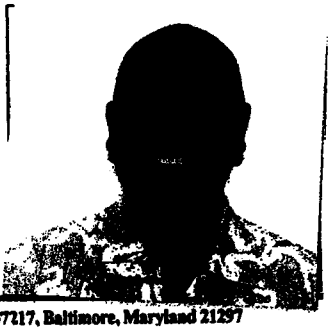
CITY/COUNTY OF Washington

I HEREBY CERTIFY that on this 26th day of May, 2009, before me, a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, _____ (print applicant's name), whose likeness is identifiable as that of the person in the photograph attached to this application and who has made oath in due form of law to be the person referred to in the above application for license to practice Medicine and Surgery in the State of Maryland, and to have stated the truth in all statements made in this application.

AS WITNESS my hand and notorial seal. Esther Marie Cuthers — Notary Public

My Commission expires: 6/30/2011

SEAL



STOP! Completed application and check must be mailed to Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297

Print Your Name: Willie James Parker Date: 06/09/09

CHECKLIST

Please review the checklist before signing page 11. A few minutes spent in review now may save days or weeks of delay in the processing your application.

06/02/2009

Control No: 105046
Parker. Willie James
Application Form (Standard)
Received: Vicktoria Rhoney
Analyst: Carol Johnson

- [x] I have provided all the personal information requested on this application (page 1)
- [x] My chronology of activities after graduating medical school is legib.
- [ ] (If applicable) I have enclosed additional sheets for my chronology.
- [x] I have provided all the information about my medical education. (ite
- [x] I have indicated how I have met Maryland's requirement for English proficiency.(Item 11. page 4)

Graduates of Foreign Medical School

- [ ] My English proficiency requirements were satisfied somewhere other than medical school, so I have requested that documentation of both written and oral proficiency be sent to the Board. (See item 11 on page 4)

I have also enclosed the following documents:

- [ ] A copy of my valid ECFMG certificate (You must take the TOEFL if ECFMG English exam was before January 1, 1974)
- [ ] A copy of my medical school diploma and a certified translation.
- [ ] If applicable a copy of the Certificate of Medical Education and Examinations Taken or Good Conduct or Intern Certificate showing my name, the name of the medical school, and the name of the affiliated university; and a certified translation. (See page 4)

- [x] I have completed Part 1 of form IML2 (follows Section V of the application) and sent a copy to the institution from which I received my medical degree and, if different, to the institution at which I received English instruction that meets the Maryland requirements.
- [x] I have listed all postgraduate training I have undertaken in the U.S., Canada, or Puerto Rico (page 5); completed Part 1 of form IML3; signed Part 2; printed my name on side B; and sent a form IML3 to the director of each program in which I participated.
- [x] I have listed all hospitals at which I have had privileges or provided services since the completion of postgraduate training and during the five year period prior to filing my application (page 6).
- [x] I have listed all medical licensing examinations I have ever taken (page 7) and sent a copy of the request for transcripts and any fee that may be required to the appropriate administering authority of each exam (see instructions after exam listed on pages 7 and 8).
- [x] I have listed every license/registration I have ever been issued in the U.S., its territories, Puerto Rico, or Canada.(page 8) and have sent a copy of IML7 to each medical board / issuing authority.
- [ ] I do not have to take the Special Purpose Exam (page 9) [ ] I must take the SPEX and have made arrangements to do so.
- [x] I have answered all character and fitness questions (page 9), explained all "yes" answers and, if applicable, enclosed all supporting documents (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgments, final orders, etc.)
- [x] I have attached a 2"x 2" passport quality photograph to the last page (page 11) of this application.
- [x] I have read the statements on page 11 of this application; signed and dated items19, 20 (if applicable), 21 and 22; and arranged to have the application notarized.
- [x] I have enclosed my check made out to "Maryland Board of Physicians" (or "MBP") in the amount of either $822.00 (Graduates of LCME-accredited American and Canadian medical schools) or $922.00 (Graduates of International Medical Schools).
- [x] I have attached the following number of pages of documentation to support this application: 6
- [x] I have signed the application in the presence of a notary and had the application notarized.

STOP! Completed application and check must be mailed to the Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297.

Initial Medical Licensure
Supplemental Form
MBP IML3
08/2008 INT

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue | P.O.Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836

Side A

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

Part 1 **APPLICANT:** Complete Part 1 and sign where indicated in the Part 2 instructions. Print your name on top of the reverse page, and send a form to the director of each postgraduate training program you attended. Be sure to copy both sides.

a. Applicant's Name: Parker Willie James
Last Name and Generational Indicator (Jr., Sr., II, III, etc.) First Name Middle Name

Address: [redacted]

City: [redacted] State: [redacted]

Date of Birth: Month Day Year [redacted] Social Security Number: [redacted]

b. Name of Institution: University of Michigan Health Systems

Department and Area of Training: Obstetrics + Gynecology, Family Planning

Complete Address: L4000 Women's Hospital 1500 E Medical Center Drive

City: Ann Arbor State: MI 48109-0276

FROM: Month 07 Year 06 TO Month 06 Year 08

Part 2 **POSTGRADUATE TRAINING PROGRAM DIRECTOR:** Please complete Part 2 according to the records available and send directly to the Maryland Board of Physicians at the above address. Please do not send original or copies to me.

Applicant's Signature: Parker, MD

1. Did the applicant participate in postgraduate training in your department during the period listed above?*
☒ YES ☐ NO If "No," please enter exact dates: _____ to _____

Program Specialty: Family Planning

*If training was part-time, please explain the training schedule after item 8 of this form.

2. During the time of the applicant's participation, was the postgraduate training program accredited? ☐ YES ☒ NO

Accredited by: ☐ ACGME: Program # _____ ☐ AOA: ID #: _____ ☐ RCPSC

3. Did the applicant participate in all of the components of the training as required by the accrediting body?
☐ YES ☐ NO Comments (attach signed and dated additions as needed): NA

4. Did the applicant successfully complete all requirements of each year of training?
☒ YES ☐ NO Comments (attach signed and dated additions as needed): _____

5. During the applicant's year(s) of training, did the applicant have any break in training?
☒ NO ☐ YES Comments (attach signed and dated additions as needed): _____

(Continued on next page)

MARYLAND BOARD OF PHYSICIANS RECEIVED JUN 10 AM 10:

Initial Medical Licensure
Supplemental Form
MBP IML3
06/2008 INT

MARYLAND BOARD OF PHYSICIANS
VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

Side B

Applicant's Name (print): Willie James Parker

6. Did the applicant have any physical or mental problem that affected the applicant's ability to practice medicine during the period of training?

☒ NO ☐ YES If "Yes," please give a detailed explanation* _____

7. Was any action taken against the applicant by any training program, hospital, medical board, licensing authority, or court ? Such actions include, but are not limited to investigations, limitations of privileges or special conditions, requirements imposed for academic incompetence, disciplinary actions, probationary actions, etc.

☒ NO ☐ YES If "Yes," please give a detailed explanation* _____

8. In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?

☒ YES ☐ NO Comments:*

Control No: 105046 06/10/2009
Parker, Willie James
IML3-Accredited Training Programs
Received: Vicktoria Rhoney
Analyst: Carol Johnson

2009 JUN 10 AM 10:10
MARYLAND BOARD OF PHYSICIANS RECEIVED

* If space is not sufficient, please attach a signed and dated detailed explanation.

Attestation: I attest that the information I have provided regarding the applicant is true, accurate, and complete according to all available records.

Timothy O Johnson
Printed Name of Program Director

Prof & Chair OB/Gyn
Title

University of Michigan
Hospital

1500 E Med. Ctr. Drive
Address Ann Arbor, MI 48109

OB/Gyn
Department

Telephone Number

Signature

5/29/09
Date

BoardCertifiedDocs

Viewed:7/
Abl

Parlear, Willie James
(Born: 10/18/1962)

ABMS Primary Source Data

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
CERTIFICATION(S):
Obstetrics & Gynecology 11/15/1996 - 12/31/2006, 12/31/2006 - 12/31/2007, 12/31/2007 - 12/31/2008, 12/31/2008 - 12/31/2009

Diplomate Self Reported Data

EDUCATION:
(MD)

LOCATION:
Kensington, MD, USA

send feedback on listing | back to search results | save specialist(s)

This profile contains primary source board certification data. Elsevier has been designated by the ABMS as an Official Display Agent and is able to provide this primary source data on behalf of the ABMS. The ABMS has been designated a primary source of board certification information by The Joint Commission (TJC), the National Committee for Quality Assurance (NCQA) and URAC.

Initial Medical Licensure
Supplemental Form
MBP IML3
08/2008 INT

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue | P.O.Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836

Cl Verified 7/13/09 92-93

Side A

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

Part 1 APPLICANT: Complete Part 1 and sign where indicated in the Part 2 instructions. Print your name on top of the reverse page, and send a form to the director of each postgraduate training program you attended. Be sure to copy both sides.

a. Applicant's Name: Parker (Last Name and Generational Indicator (Jr., Sr., II, III, etc.)) Willie (First Name) James (Middle Name)

Address: [redacted]

City: [redacted] State: [redacted]

Date of Birth: [redacted] (Month Day Year) Social Security Number: [redacted]

b. Name of Institution: University of Cincinnati Hospitals

Department and Area of Training: Obstetrics and Gynecology

Complete Address: Medical Sciences Bldg, Room 5255A, 231 Albert B Sabin Wy PO Box 45267-0526

City: Cincinnati State: OHIO

FROM: Month 07 Year 90 TO Month 06 Year 94

Part 2 POSTGRADUATE TRAINING PROGRAM DIRECTOR: Please complete Part 2 according to the records available and send directly to the Maryland Board of Physicians at the above address. Please do not send original or copies to me.

Applicant's Signature: WT Parker, MD

1. Did the applicant participate in postgraduate training in your department during the period listed above?*

☒ YES ☐ NO If "No," please enter exact dates: _____ to _____

Program Specialty: OB/GYN

*If training was part-time, please explain the training schedule after item 8 of this form.

2. During the time of the applicant's participation, was the postgraduate training program accredited? ☒ YES ☐ NO

Accredited by: ☒ ACGME: Program # 2203821229 ☐ AOA: ID #: _____ ☐ RCPSC

3. Did the applicant participate in all of the components of the training as required by the accrediting body?

☒ YES ☐ NO Comments (attach signed and dated additions as needed): _____

4. Did the applicant successfully complete all requirements of each year of training?

☒ YES ☐ NO Comments (attach signed and dated additions as needed): _____

5. During the applicant's year(s) of training, did the applicant have any break in training?

☒ NO ☐ YES Comments (attach signed and dated additions as needed): _____

(Continued on next page)

MARYLAND BOARD OF PHYSICIANS RECEIVED JUN 22 AM 8:

Initial Medical Licensure
Supplemental Form
MBP IML3
09/2008 INT

MARYLAND BOARD OF PHYSICIANS
VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

Side B

Applicant's Name (print): Willie James Parker

6. Did the applicant have any physical or mental problem that affected the applicant's ability to practice medicine during the period of training?

[X] NO [ ] YES If "Yes," please give a detailed explanation* _____

7. Was any action taken against the applicant by any training program, hospital, medical board, licensing authority, or court ? Such actions include, but are not limited to investigations, limitations of privileges or special conditions, requirements imposed for academic incompetence, disciplinary actions, probationary actions, etc.

[X] NO [ ] YES If "Yes," please give a detailed explanation* _____

8. In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?

[X] YES [ ] NO Comments:*

06/22/2009

Control No: 105046
Parker, Willie James
IML3-Accredited Training Programs
Received: Vicktoria Rhoney
Analyst: Carol Johnson

* If space is not sufficient, please attach a signed and dated detailed explanation.

Attestation: I attest that the information I have provided regarding the applicant is true, accurate, and complete according to all available records.

Arthur Allendorff
Printed Name of Program Director

Residency Program Director
Title

University Hospital
Hospital

231 Albert Sabin Way Cincinnati OH 45267
Address

OB/GYN
Department

513-558-2860
Telephone Number

Signature

6/4/09
Date

Initial Medical Licensure
Supplemental Form
MBP IML2
06/2006 INT

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue | P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836

VERIFICATION OF EDUCATION AND ENGLISH LANGUAGE INSTRUCTION

Part 1 APPLICANT: Complete Part 1 and send to the institution which issued your medical degree. If you satisfi English language competency requirements somewhere other than your medical school, also send a copy that institution and ask them to return the completed form directly to the Board.

Name: Parker (Print last name and generational indicator (Jr., Sr., II, III, etc.)) Willie (First name) Jame (Middle name)

Date of Birth: Month [redacted] Social Security Number: [redacted]

School Attended: University of Iowa College of M (Only medical school, undergraduate school, or high school)

Affiliated with (if applicable): _____ (Name of institution that conferred your degree, if different from medical colleg)

Attended from: 06/86 to 05/90 Date of Graduation: 05/04/90

Part 2 REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please complete this form and mail it to-thi

I hereby certify that the above-named individual attended this institution during the inclusive dat

Month 06 Day 09 Year 86 to Month 05 Day 04 Year 90 ; that all academic studies were

language(s) of English ; that all clinical clerkships were

language(s) of English ; and that he/she was conferred

[X] M.D. [ ] D.O. [ ] M.D./Ph.D [ ] M.B.B.S. [ ] M.B.B.Ch [ ] Other:_____ (specify)

on Month 05 Day 04 Year 90 after he/she had satisfied all prerequisite obligations.

Damien Ihrig
Printed Name of Authorized Official

University of Iowa
Carver College of Medicine
Name of Institution

COM Registrar
Title of Authorized Official

319-335-16823
Telephone Number

319-335-8643
Fax Number

Signature of Authorized Official

06/05/2009
Date

S
O
INST

PROGRAM SEARCH - VIEW PROGRAM

Back to Search Results

PROGRAM INFORMATION

University Hospital/University of Cincinnati College of Medicine Program [2203821229]

University of Cincinnati Medical Center
231 Albert Sabin Way, ML 0526
Cincinnati, Ohio 45267

http://www.med.uc.edu/obgyn/education/residency.cfm

Sponsoring Institution: University Hospital Inc
Specialty: Obstetrics and Gynecology

DIRECTOR INFORMATION

Arthur T. Ofendorff, MD
Residency Program Director, Obstetrics and Gynecology
Director First Appointed: September 1, 2002
Phone: (513) 558-2660
Fax: (513) 558-6138
Email:

COORDINATOR INFORMATION

Michelle C. Doll
Program Coordinator

Phone: (513) 558-7653
Email: dollme@ucmail.uc.edu

ACCREDITATION AND GENERAL INFORMATION

Original Accreditation Date: July 21, 1952
Accreditation Status: Continued Accreditation
Accreditation Effective Date: January 24, 2008
Accredited Program Length: 4 years

Program Format: Standard

Last Site Visit Date: August 7, 2007
Cycle Length: 4 years
Approximate Date of Next Site Visit: January 1, 2012

Program Requires Prior or Additional GME Training: NO
Program Requires Dedicated Research Year: NO
Government Affiliation: No Military or Government Affiliation

ACGME APPROVED POSITIONS

Year 1 Positions: 7
Year 2 Positions: 7
Year 3 Positions: 7
Year 4 Positions: 7
Total ACGME Approved Positions: 28

ACGME FILLED POSITIONS (CATEGORICAL AND PRELIMINARY POSITIONS ONLY)

Year 1 Filled Positions: 7
Year 2 Filled Positions: 7
Year 3 Filled Positions: 7
Year 4 Filled Positions: 7
Total Number of Filled Positions: 28

PARTICIPATING INSTITUTIONS AND ROTATIONS

University Hospital Inc - Sponsor
Type of Rotation: Required
Year 1 Months of Rotation: 8
Year 2 Months of Rotation: 8
Year 3 Months of Rotation: 6
Year 4 Months of Rotation: 10

Christ Hospital - Participating Institution
Type of Rotation: Required
Year 1 Months of Rotation: 2
Year 2 Months of Rotation: 4
Year 3 Months of Rotation: 6
Year 4 Months of Rotation: 2

St. Luke Hospital West - Participating Institution
Type of Rotation: Required
Year 1 Months of Rotation:
Year 2 Months of Rotation:
Year 3 Months of Rotation:
Year 4 Months of Rotation:

St Luke Hospital East - Participating Institution
Type of Rotation: Required
Year 1 Months of Rotation:
Year 2 Months of Rotation:
Year 3 Months of Rotation:
Year 4 Months of Rotation:

Cincinnati Children's Hospital Medical Center - Participating Institution
Type of Rotation: Required
Year 1 Months of Rotation:
Year 2 Months of Rotation:
Year 3 Months of Rotation:
Year 4 Months of Rotation:

Veterans Affairs Medical Center (Cincinnati) - Participating Institution
Type of Rotation: Required
Year 1 Months of Rotation:
Year 2 Months of Rotation:
Year 3 Months of Rotation:
Year 4 Months of Rotation:

COMMENTS

The department of OB/GYN is in the process of expanding its clinical services and simultaneously developing innovative ways to teach and evaluate the pre-requisite skills to become an excellent physician.

Department of Consumer Affairs

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

May 25, 2009

TO WHOM IT MAY CONCERN:

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

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

This license information was last updated on: 05/21/2009

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

Deborah Pellegrini

DEBORAH PELLEGRINI
CHIEF OF LICENSING

[redacted]

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

★ ★ ★

[redacted]

Health Professional
Licensing Administration

Dear Sir or Madam:

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

Name:	WILLIE J PARKER
License Type:	MEDICINE AND SURGERY
License Number:	MD037446
Original Licensure Date:	06/30/2008
Expiration Date:	12/31/2010
Obtained By:	Waiver of Examination
License Status:	Active
Other:	BEREA COLLEGE 05/01/1986 HARVARD SCHOOL OF PUBLOC HEALTH 06/01/1998 UNIVERSITY OF IOWA COLLEGE OF /01/1990

[redacted] MARYLAND BOARD OF PHYSICIANS RECEIVED JUN - 4

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

Sincerely,

Jeseka Weldon

Acting Executive Director
D.C. Boards of Medicine and Chiropractic

SEAL

Certified By: Alma White DOH
Title: Health Licensing Specialist
Date: May 29, 2009

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

06/06/09

ARYLAND BOARD OF PHYSICIANS
1201 PATTERSON AVE
O BOX 2571
ALTIMORE MD 21215

E: VERIFICATION OF LICENSE/EXAM SCORES DATED 06/09/09 FOR
WILLIE PARKER

OARD/COMMISSION: HAWAII MEDICAL BOARD

ICENSE TYPE: PHYSICIAN

ICENSE IDENTIFICATION: MD 11733

ETHOD OF LICENSURE: PASSED FLEX

ATE LICENSED: 10/11/01

ICENSE STATUS: CURRENT, VALID & IN GOOD STANDING

ICENSE EXPIRATION DATE: 01/31/10

ISCIPLINARY ACTION: NONE

CCORDING 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. Ca

CONSTANCE CABRAL
EXECUTIVE OFFICER

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER
GOVERNOR
PATTY JUDGE
LT. GOVERNOR

IOWA BOARD OF MEDICINE
MARK BOWDEN
EXECUTIVE DIRECTOR

May 25, 2009

Verification of Licensure

Maryland State Board of Physicians
P.O. Box 2571
Baltimore, MD 21215

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

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

This license information was last updated on: 05/25/2009

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

Sincerely,

Sylvia M Crook

Sylvia Crook
Licensing Specialist

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

JENNIFER M. GRANHOLM
Governor

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
Director

VERIFICATION OF LICENSURE
MICHIGAN BOARD OF MEDICINE
VERIFICATION OF LICENSURE AS OF 05/25/2009

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

ADDRESS: 635 Liberty Pointe Dr
Ann Arbor MI 481030000

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

LICENSE NUMBER: 4301067666 **STATUS:** Active **EXPIRATION DATE:** 01/31/2010

OBTAINED BY: Endorsement - Licensed >= 10 Years

DISCIPLINARY ACTION NONE

OPEN FORMAL COMPLAINTS NONE

This license information was last updated on: 05/25/2009

State Medical Board of Ohio

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

VERIFICATION OF LICENSURE

This is to verify that the records of the State Medical Board of Ohio contain the following information for the indicated licensee as of 6/3/2009:

Identification Information

Name:	Dr. WILLIE JAMES PARKER 635 Liberty Pointe Ann Arbor, MI 48103
Date of Birth:	10/18/1962
Place of Birth:	BIRMINGHAM, AL
School of Graduation:	Des Moines University - Osteopathic Medical Center
Date of Graduation:	05/04/90

License Information

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

Debra L. Jones

Debra Jones
CME and Renewal Officer

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Application for renewal of: **Physicians** 2009

1. **License Number D0069574** Dr. Willie James Parker

2.	Individual National Provider Identifier NPI: 1841203536 ☒ I do not have an NPI This is the NPI entered in the field for Rendering NPI on a claim (10 digit number) NPI Information

3. EMAIL ADDRESS: This is your email address on file. If it has changed, please edit below. If you do not have an email address please indicate by checking the checkbox below.

berean86wp@yahoo.com

☒ I do not have an email address

Address Changes (Non-Public and Public):
You must submit a Public and Non-Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of July 1, 2012 . If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

4a. Non-Public Address: This address is for Board use only and is **where your license will be mailed**. However, if no public address is listed, this address will also be made available to the public.

Street [redacted]
Street (2)
Street (3)
City
State
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode
Country United States

4b. Public Address: This address, usually your office, is available to the public and will be posted on the Internet. If you do not designate a public address, your non-public address will be posted on the Internet.

☒ Check if Public Address is the same as your Non-Public address (the address above will be automatically entered below.)

Street 1400 Spring Street
Street (2) #450
Street (3)
City Silver Spring
State Maryland
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode 20910
Country United States

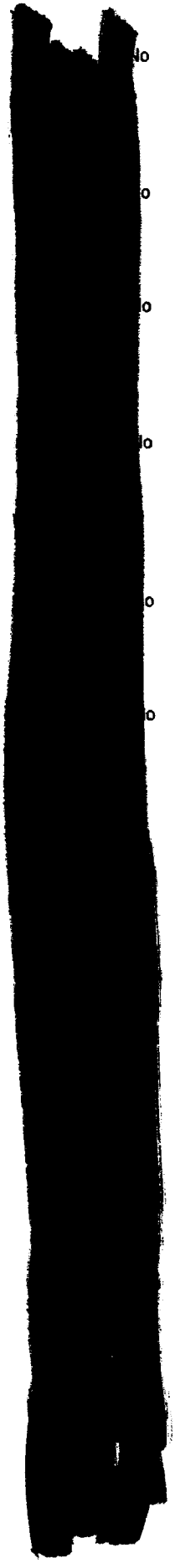
5. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction ● Yes ○ No

CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2010. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.***
* All questions must be answered Yes or No.

[redacted]

a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?



b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board) or an entity of the armed services?

c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?

e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?

g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?

i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?

j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

k. Do you illegally use drugs?

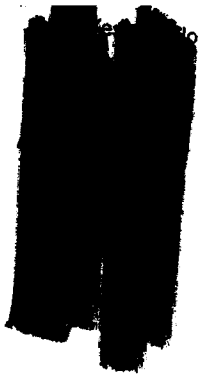
l. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?

m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?

I have not been named since my original license application

n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?

Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or



o. military entity while under investigation by that institution for disciplinary reasons?

p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?

q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

CONTINUING MEDICAL EDUCATION (Question 7)

- (●) **a. CME met.** I have earned 50 credit hours of Category 1 continuing medical education during the two (2) years prior to this renewal.
- (●) **b. First Renewal & NPO.** I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for **NEWLY** licensed physicians only. If you were licensed prior to September 30, 2010 or reinstated, this does not apply to you. See New Physician Orientation Program web site. **Your license will not be renewed unless you have completed the orientation.**
- (●) **c. First Renewal after reinstatement.** I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

[redacted]thnicity and Race: (Select all that apply)

- [ ] Hispanic or Latino
- [ ] American Indian or Alaska native
- [ ] Asian
- [ ] Black or African American
- [ ] Native Hawaiian or other Pacific Islander
- [ ] White
- [ ] Other

---

9. Are you employed by the Federal Government?

(●) Yes (●) No

---

10. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical Education or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship (subspecialty) training program accredited by the ACGME.

(●) If you answer *Yes* to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of this application.

In an accredited/approved internship or residency program?

(●) Yes (●) No

In an accredited fellowship (subspecialty) training program?

(●) Yes (●) No

Which best describes your current area(s) of concentration:

Primary Concentration: Obstetrics & Gynecology [General]

Secondary Concentration: None

12. SPECIALTY BOARD CERTIFICATION: List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Primary Certification: Obstetrics & Gynecology [General]

Secondary Certification: None

13. Please indicate below how the hours in your typical work week are allocated. The sum of these hours should reflect the number of hours in your typical work week. Definitions of these categories are listed below.

If you allocate **0 hours per week** to a. Patient Care Related Activities you will not be required to complete the Practice Information section (Questions 15-26) of this application.

Patient Care Related Activities include seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic and radiologic assessments), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with other providers about patients, talking with a patient's family members.

Research includes clinical, laboratory, and analytical research

Teaching includes teaching of medical undergraduate & graduate students and other graduate students.

Administration & Other: Administration includes practice management (billing, contract negotiations, personnel, regulatory activities) & management of institutions or programs (health departments, health insurance, hospitals, other health-related institutions or programs); Other

Use whole numbers. No fractional hours. If none enter 0.

a. Patient Care Related Activities	[redacted] hours per week
b. Research	hours per week
c. Teaching	hours per week
d. Administration & Other	hours per week
Total Hours	hours per week

14. If you indicated in Question 13 that you are not engaged in patient care related activities, do you intend to resume patient care related activities in the next 2 years?

○ Yes ○ No

PRACTICE INFORMATION (Questions 15-26)

15. Do you plan to discontinue patient care related activities in the next two years?

[redacted] Yes [redacted] No

16. Please indicate below the number of practice/office locations at which you routinely deliver patient care for reimbursement.

a. Number of locations in Maryland (if none, enter 0) 1

b. Number of locations outside of Maryland (if none, enter 0) 2
If you have locations outside Maryland, please answer (c) below after you answer (b).

c. Do you routinely treat Maryland patients at your practice/office location(s) outside of Maryland?
Yes No Don't know

17. Please indicate below the number of hospitals at which you currently have admitting privileges.

a. Number of hospitals in Maryland (if none, enter 0) 0

b. Number of hospitals outside of Maryland (if none, enter 0) 1

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18. Primary Practice / Office Location Primary Practice / Office Location

Please answer all Primary Practice questions

a. Organization Name: Planned Parenthood Metro Washington

b. Street Address: 1108 16th Street NE

c. Street2:

Enter suite or room number here. (Ex. Suite 101 or Room 101)

d. City: Washington

e. State: District of Columbia

f. Zip Code: 20036

g. Jurisdiction: Non-Maryland

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h. Employer Tax ID [redacted] What is Employer tax ID?

Enter "None" if you do not have an Employer tax ID

---

i. Please select one of the following related to the NPI used for billing insurers:

- I use an Organizational NPI for billing. Please Enter > Organizational NPI
- I use my Individual NPI for billing.
- I do not bill public or private insurers.

---

j. You indicated in Question 13 total typical work week hours of 48 .
How many of the patient care related activity hours in your typical work week are delivered at this practice/office location? 28 Hours

If none, enter 0.

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k. Setting: Other Clinic

l. Private/Public: Private-Not for profit

m. Practice: Staff Non-Acute Care Facility

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19. Secondary Practice / Office Location

If you have a secondary practice/office location and you've checked the box above, you will see a series of questions that must be completed.

a. Organization Name: Planned Parenthood Metro. Washington

b. Street Address: 1400 Spring Street, Ste 450

c. Street2:

Enter suite or room number (Ex. Suite 101 or Room 101)

d. City: Silver Spring

e. State: Maryland

f. Zip Code: 20910

g. Jurisdiction: MONTGOMERY

h. Employer Tax ID: [redacted] What is Employer tax ID?

Enter None if you do not have an Employer tax ID

i. Please select one of the following related to the NPI used for billing insurers:

- I use an Organizational NPI for billing. Please Enter > Organizational NPI
- I use my individual NPI for billing.
- I do not bill public or private insurers.

j. You indicated in Question 13 total typical work week hours of 48 .
How many of the patient care related activity hours in your typical work week are delivered at this practice/office location? 6 Hours

If none, enter 0.

k. Setting: Other Clinic

l. Private/Public: Private-Not for profit

m. Practice: Staff Non-acute Care Facility

20. Information Technology (Primary Practice / Office Location)

Please answer all Primary Practice Information Technology questions

This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients at your primary office/practice location, which you listed in question 18.

- Yes / No — A. To obtain information about treatment alternatives or recommended guidelines?
- Yes / No — B. To send prescriptions electronically to a pharmacy?

  If you answered **Yes** to 20B, what percentage of prescriptions are submitted electronically? Use whole numbers. %
- Yes / No — C. To generate reminders for you about preventive services needed for your patients?
- Yes / No — D. To access patient notes, medication lists, or problem lists?
- Yes / No — E. For clinical data and image exchanges **WITH OTHER PHYSICIANS**?
- Yes / No — F. For clinical data and image exchanges **WITH HOSPITALS AND LABORATORIES**?
- Yes / No — G. To communicate about clinical issues with patients by email?
- Yes / No — H. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?

21. Does your primary office/practice location use electronic MEDICAL RECORDS (not including billing records)?

Yes, all electronic / Yes, part paper and part electronic / No / Don't know

21a. **If No,** please indicate your most significant reason for not using electronic medical records.

- [ ] Capital cost outlays
- [ ] Overburdened staff
- [ ] Physician resistance to adoption
- [ ] Risk of privacy breaches
- [ ] Lack of technology standards
- [ ] Intangible benefits
- [ ] Retiring soon
- [ ] Not my decision

22. Please indicate if you participate in the following private and public insurance programs, and whether you are currently accepting new public insurance program patients.

a. Participate in any PRIVATE insurance plan networks, including PPO, EPO, HMO, etc. (●) Yes ( ) No

b. Participate in the MARYLAND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed Care Organization) (●) Yes ( ) No

b1. If **Yes**, are you accepting new Maryland Medical Assistance patients? ( ) Yes (●) No

c. Participate in the MEDICARE (in either the traditional program or a Medicare Advantage Plan)? (●) Yes ( ) No

c1. If **Yes**, are you accepting new Medicare patients? ( ) Yes (●) No

23. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)
(●) Yes ( ) No ( ) NA

24. Please report the typical number of hours per week you personally provide care to patients on a charity basis (do not include bad debt).
0 hours per week. If none, enter 0

If you are practicing as an adult primary care specialist (internal medicine, family practice, general medicine), answer Q.25. Otherwise skip to Q.26.

25. Do you charge patients an annual fee for participating on your patient panel (sometime called direct, concierge, or retainer-based practice)?
( ) Yes ( ) No

26. Workers Compensation

Workers Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I hereby certify:

- [ ] Not Applicable (Do not complete below)
- [ ] I do not practice in Maryland.
- [ ] I do not employ anyone in my practice in Maryland.
- [ ] I employ one or more persons in my Maryland practice and have the following Workers Compensation coverage.

If you are a Maryland employer you must provide the information requested below.

Insurance Company
Policy Number
Expiration Date

Enter as MM/DD/YYYY Enter as MM/DD/YYYY

PHYSICIANS EMERGENCY CONTACT INFORMATION

27. As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has identified the need for certain contact information for licensed physicians in Maryland who may be needed to

respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental Hygiene.

* Required Field

Please provide the phone number that should be used in the event of an actual emergency.

Daytime * [redacted]

Nighttime*

Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents:

☐ Chemical ☐ Biological ☐ Radiological

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at http://bioterrorism.dhmh.state.md.us/volunteer.htm.

Thank you for your assistance!

APPLICATION PACKET FOR EXEMPTION FROM LICENSE FEE

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28. CERTIFICATION AND AUTHORIZATION OF LICENSE APPLICATION

Please check the first 3 boxes to certify and affirm your renewal application.

☑ a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my applicatio may be cause for the denial of my application.

☑ b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hosp and other licensing bodies, and I agree that any person or agency may release to the Board the information requeste also agree to sign any subsequent releases for information that may be requested by the Board.

☑ c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grou for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application pe (b) change in any answer that was originally given in this application.

☑ d. Check Here if you wish to have the option of viewing your completed application online after you renew your licens Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 12/1/2012.

29. Please provide your electronic signature (type your name) below:

Name: Willie J. Parker, MD, MPH

Today's Date: 9/21/2009

Last four digits of Social Security Number: [redacted]

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30. Select a Payment Option here to complete your application.

Please note: Credit cards may be used for online payment only. If you or a 3rd party is sending in payment, it must be by check.

Your renewal fee is:

● Credit Card ● Send Check ● 3rd Party Check 3rd Party Payer: [redacted]

PAYMENT

APPLICATION COMPLETION INFORMATION:

Date Application Started	9/9/2009
Date Application Submitted	9/21/2009
Confirmation Number	[redacted]
Payment Method	
Amount Paid	
Credit Card Approval No.	

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Application for renewal of: **Physicians**

2011

1. **License Number D0069574** Dr. Willie James Parker

2. Individual National Provider Identifier NPI: 1841203536 ☑ I do not have an NPI
This is the NPI entered in the field for Rendering NPI on a claim (10 digit number)
☐ NPI Information

3. **EMAIL ADDRESS**: This is your email address on file. If it has changed, please edit below. If you do not have an email address please indicate by checking the checkbox below.

berean86wp@yahoo.com

☑ I do not have an email address

Address Changes (Non-Public and Public):
You must submit a Public and Non-Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of July 1, 2012 . If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

4a. Non-Public Address: This address is for Board use only and is **where your license will be mailed**. However, if no public address is listed, this address will also be made available to the public.

Street [redacted]
Street (2)
Street (3)
City [redacted]
State [redacted] If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode [redacted]
Country United States

4b. Public Address: This address, usually your office, is available to the public and will be posted on the Internet. If you do not designate a public address, your non-public address will be posted on the Internet.

☑ Check if Public Address is the same as your Non-Public address (the address above will be automatically entered below.)

Street 1400 Spring Street
Street (2) #450
Street (3)
City Silver Spring
State Maryland
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode 20910
Country United States

5. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction ● Yes ○ No

CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2010. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.***
* All questions must be answered Yes or No.

[redacted]

a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

[redacted]

b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board) or an entity of the armed services?

c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?

e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?

g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?

i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?

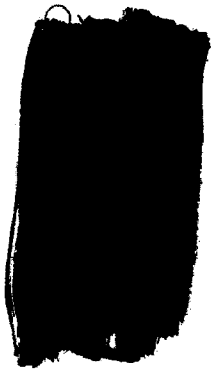
j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

k. Do you illegally use drugs?

l. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?

m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?

n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?



o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?

p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?

q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

CONTINUING MEDICAL EDUCATION (Question 7)

(●) **a. CME met.** I have earned 50 credit hours of Category 1 continuing medical education during the two (2) years prior to this renewal.

( ) **b. First Renewal & NPO.** I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for **NEWLY** licensed physicians only. If you were licensed prior to September 30, 2010 or reinstated, this does not apply to you. See New Physician Orientation Program web site. **Your license will not be renewed unless you have completed the orientation.**

( ) **c. First Renewal after reinstatement.** I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

8a. Gender (●) Male ( ) Female

8b. Ethnicity and Race: (Select all that apply)

[redacted] Hispanic or Latino

American Indian or Alaska native

Asian

Black or African American

Native Hawaiian or other Pacific Islander

White

Other

. Are you employed by the Federal Government?

( ) Yes (●) No

). Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical ducation or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship ubspecialty) training program accredited by the ACGME.

If you answer *Yes* to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of s application.

In an accredited/approved internship or residency program?

) Yes (●) No

In an accredited fellowship (subspecialty) training program?

○ Yes ◉ No

11. Which best describes your current area(s) of concentration:

Primary Concentration: Obstetrics & Gynecology

Secondary Concentration: Gynecology

12. SPECIALTY BOARD CERTIFICATION: List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Primary Certification: Obstetrics & Gynecology

Secondary Certification: None

13a. How many weeks per year do you work? 46

13b. Please indicate below how the hours in your typical work week are allocated. The sum of these hours should reflect the number of hours in your typical work week. Definitions of these categories are listed below.

If you allocate **0 hours per week** to a. Patient Care Related Activities you will not be required to complete the Practice Information section (Questions 15-26) of this application.

Patient Care Related Activities include seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic and radiologic assessments), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with other providers about patients, talking with a patient's family members.

Research includes clinical, laboratory, and analytical research

Teaching includes teaching of medical undergraduate & graduate students and other graduate students.

Administration & Other: Administration includes practice management (billing, contract negotiations, personnel, regulatory activities) & management of institutions or programs (health departments, health insurance, hospitals, other health-related institutions or programs); Other

Use whole numbers. No fractional hours. If none enter 0.

a. Patient Care Related Activities	32	hours per week
b. Research	0	hours per week
c. Teaching	0	hours per week
d. Administration & Other	6	hours per week
Total Hours	38	hours per week

14. If you indicated in Question 13 that you are not engaged in patient care related activities, do you intend to resume patient care related activities in the next 2 years?

○ Yes ○ No

PRACTICE INFORMATION (Questions 15-26)

15. Do you plan to discontinue patient care related activities in the next two years?

○ Yes ◉ No

16. Please indicate below the number of practice/office locations at which you routinely deliver patient care for reimbursement.

a. Number of locations in Maryland (if none, enter 0) 1

b. Number of locations outside of Maryland (if none, enter 0) 0
If you have locations outside Maryland, please answer (c) below after you answer (b).

c. Do you routinely treat Maryland patients at your practice/office location(s) outside of Maryland?
Yes No Don't know

17. Please indicate below the number of hospitals at which you currently have admitting privileges.

a. Number of hospitals in Maryland (if none, enter 0) 0

b. Number of hospitals outside of Maryland (if none, enter 0) 1

18. Primary Practice / Office Location Primary Practice / Office Location

Please answer all Primary Practice questions

a. Organization Name: Planned Parenthood Metro Washington

b. Street Address: 1108 16th Street NE

c. Street2:
Enter suite or room number here. (Ex. Suite 101 or Room 101)

d. City: Washington

e. State: District of Columbia

f. Zip Code: 20036

g. Jurisdiction: MONTGOMERY

h. Employer Tax ID: 00 - 0000000 If you do not have an EIN enter 00-0000000
What is Employer tax ID?

i. Please select one of the following related to the NPI used for billing insurers:

I use an Organizational NPI for billing. Please Enter > Organizational NPI

I use my Individual NPI for billing.

I do not bill public or private insurers.

j. You indicated in Question 13a, 32 hours of Patient Care Related Activities during a typical work week.
How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location?
If none, enter 0. 8 Hours

k. Setting: Free Standing Medical Facility

l. Private/Public: Private-Not for profit

m. Practice: Other Contractual-Associate Staff (Individual only)

19. Secondary Practice / Office Location
No Secondary Location indicated from your response in Question 16.
If you have a secondary practice/office location and you've checked the box above, you will see a series of questions that must be completed.

20. Information Technology (Primary Practice / Office Location)

Please answer all Primary Practice Information Technology questions

This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients at your primary office/practice location, which you listed in question 18.

○ Yes ● No A. To obtain information about treatment alternatives or recommended guidelines?

○ Yes ● No B. To send prescriptions electronically to a pharmacy?

If you answered **Yes** to 20B, what percentage of prescriptions are submitted electronically? Use whole numbers. [ ] %

○ Yes ● No C. To generate reminders for you about preventive services needed for your patients?

○ Yes ● No D. To access patient notes, medication lists, or problem lists?

○ Yes ● No E. For clinical data and image exchanges **WITH OTHER PHYSICIANS?**

● Yes ○ No F. For clinical data and image exchanges **WITH HOSPITALS AND LABORATORIES?**

● Yes ○ No G. To communicate about clinical issues with patients by email?

● Yes ○ No H. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?

21. Does your primary office/practice location use electronic MEDICAL RECORDS (not including billing records)?

○ Yes, all electronic ○ Yes, part paper and part electronic ● No ○ Don't know

21a. If **No**, please indicate your most significant reason for not using electronic medical records.

○ Capital cost outlays ○ Risk of privacy breaches ○ Retiring soon

○ Overburdened staff ○ Lack of technology standards ● Not my decision

○ Physician resistance to adoption ○ Intangible benefits

22. Please indicate if you participate in the following private and public insurance programs, and whether you are currently accepting new public insurance program patients.

a. Participate in any PRIVATE insurance plan networks, including PPO, EPO, HMO, etc. ● Yes ○ No

b. Participate in the MARYLAND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed Care Organization) ○ Yes ● No

b1. If **Yes**, are you accepting new Maryland Medical Assistance patients? ○ Yes ○ No

c. Participate in the MEDICARE (in either the traditional program or a Medicare Advantage Plan)? ○ Yes ● No

c1. If **Yes**, are you accepting new Medicare patients? ○ Yes ○ No

23. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)

○ Yes ○ No ● NA

24. Please report the typical number of hours per week you personally provide care to patients on a charity basis (do not include bad debt).

4 hours per week. ● If none, enter 0

If you are practicing as an adult primary care specialist (internal medicine, family practice, general medicine), answer Q.25. Otherwise skip to Q.26.

25. Do you charge patients an annual fee for participating on your patient panel (sometime called direct, concierge, or retainer-based practice)?

● Yes ● No

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26. Workers Compensation

Workers Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I hereby certify:

● Not Applicable (Do not complete below)

● I do not practice in Maryland.

● I do not employ anyone in my practice in Maryland.

● I employ one or more persons in my Maryland practice and have the following Workers Compensation coverage.

● If you are a Maryland employer you must provide the information requested below.

Insurance Company

Policy Number

Expiration Date ● Enter as MM/DD/YYYY Enter as MM/DD/YYYY

PHYSICIANS EMERGENCY CONTACT INFORMATION

27. As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental Hygiene.

* Required Field

Please provide the phone number that should be used in the event of an actual emergency.

Daytime *

Nighttime*

Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents:

☐ Chemical ☐ Biological ☐ Radiological

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at https://mdresponds.dhmh.maryland.gov/.

Thank you for your assistance!

APPLICATION PACKET FOR EXEMPTION FROM LICENSE FEE

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28. CERTIFICATION AND AUTHORIZATION OF LICENSE APPLICATION

☑ a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.

☑ b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

☑ c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period; (b) change in any answer that was originally given in this application.

☑ d. Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 12/1/2012.

Electronic Health Record Incentive

Beginning in 2011, physicians that adopt an electronic health record are eligible to receive an incentive either under Medicare or Medicaid. To receive this incentive, a physician must meet certain criteria, which varies depending on which program you choose. The Medicare incentive is up to $44,000 over five years and the Medicaid incentive is up to $63,750 over six years. Physicians are encouraged to learn more about these incentive opportunities by visiting the Centers for Medicare and Medicaid Services website http://www.cms.gov/EHRIncentivePrograms/

29. Please provide your electronic signature (type your name) below:

Name: Willie J. Parker

Today's Date: 9/28/2011

Last four digits of Social Security Number: [redacted]

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30. Select a Payment Option here to complete your application.

Please note: Credit cards may be used for online payment only. If you or a 3rd party is sending in payment, it must be by check.

Your renewal fee is:

● Credit Card ○ Send Check ○ 3rd Party Check 3rd Party Payer: [redacted]

PAYMENT