[redacted] "Yes"

RENEWAL APPLICATION

DEPT. OF COMMERCE & CONSUMER AFFAIRS STATE OF HAWAII
PROFESSIONAL & VOCATIONAL LICENSING DIVISION
P.O. BOX 3469, HONOLULU, HI 96801

This form is for the renewal of your license for the next license period. FEB 08 - JAN 10
Instructions & information are on the enclosed sheet. DO NOT USE THIS FORM AFTER JAN 31 10

BOARD OF MEDICAL EXAMINERS — PHYSICIAN

LICENSE DATA

LICENSEE'S NAME & ADDRESS OF RECORD:

SEE ATTACHED

Willie Parker

LICENSE NO: MD -
FILE NO:

308 00653762	13- 1/30/09	200.00
301 00653763	13- 1/30/09	90.00

FEES

By LICENSE EXPIRATION DATE JAN 31 08 a TOTAL of $240.00 is due. <---------- *** [ON-TIME FEE] ***

AFTER the LICENSE EXPIRATION DATE JAN 31 08 AND BEFORE JAN 31 10, a TOTAL of $290.00 is due. <---------- *** [LATE FEE] ***

POSTED JAN 27 2009

Please make check or money order payable to: COMMERCE AND CONSUMER AFFAIRS (DO NOT MAKE MULTIPLE PAYABLE)

OTHER REQUIREMENTS

OTHER REQUIREMENTS DUE or SPECIAL INSTRUCTIONS/INFORMATION:

10% COMPLIANCE RESOLUTION FUND (CRF) & 25% RENEWAL (REN) CUSTOMER APPRECIATION CREDIT ONLINE DISCOUNTS!

Renew online at http://pvl.ehawaii.gov/renewals by 01/31/08 and receive 10% off the $40 CRF fee and 25% off the $150 REN fee and pay a total cost of $193.50 to renew.
(DOES NOT APPLY to MAIL-IN RENEWALS)

CONTINUING MEDICAL EDUCATION (CME): Information on CME req. on website: www.hawaii.gov/dcca/areas/pvl/boards/medical.

AUDIT: Audited physicians were notified by mail on 10/2008 that SUBMITTAL of CME documentation is required. Therefore, these physicians may NOT renew online.

WAIVER/MODIFICATION OF CME: Any physician not meeting the CME requirement due to incapacity, undue hardship or other extenuating circumstances may request a waiver in writing. The written request must be NOTARIZED and include an explanation as to why the CME requirement was not met. Physicians exercising this option may NOT renew online.

No CME's are required of physicians initially licensed after 1/31/07.

INCOMPLETE APPLICATION WILL DELAY PROCESSING

CERTIFICATION: By submitting this renewal, unless I am requesting a waiver/modification, I certify that I have met the CME requirement as contained in Subchapter 5 of the Board's Rules.

(/) ADDRESS CHANGED? Provide new mailing address below:

[redacted]

( ) NAME CHANGED? Attach a copy of name change document.

A license that has been forfeited for one renewal term (two years) shall be automatically terminated and cannot be restored. A new application for licensure will be required.

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808)586-3000 to submit your request.

POSTED JAN 27 2009

RESTORATION

TO BE COMPLETED BY LICENSEE

PLEASE REFER TO THE QUESTIONS ON THE REVERSE SIDE OF THE RENEWAL APPLICATION. ALL QUESTIONS MUST BE ANSWERED IN ORDER FOR YOUR RENEWAL TO BE PROCESSED.

I understand that my license expires on the License Expiration Date shown on this form. I understand that if I fail to renew my license by the license expiration date I am unlicensed and shall not practice. I further understand that I may resume practice only after I have met all appropriate restoration requirements.

I certify that the statements contained in this application are true and correct. I understand that misrepresentation is grounds for board refusal to renew or subsequent suspension or revocation of license.

SIGNATURE OF LICENSEE [redacted] DATE 7/15/08

HAVE YOU REMEMBERED TO:
1) Attach payment.
2) Answer applicable questions.
3) Sign and date application.
4) If applicable, include required documents.

FOR DCCA ACCOUNTING OFFICE ONLY

TOTAL (ON TIME): $240.00		TOTAL (LATE): $290.00	
REN...300	150.00	REC...308	200.00
CRF...301	90.00	CRF...301	90.00

LICENSE NO: MD 11733

OK w 1-26-09

ON TIME: $240.00

LATE: $290.00

SEE ATTACHED

TO BE COMPLETED BY LICENSEE (Circle your answers and provide additional information where requested):

1) In the past two years, with regard to any medical license to practice in any state or country:
   a) Has it ever been revoked, suspended, placed on probation, surrendered, reprimanded, admonished, or otherwise subject to disciplinary action; or have you ever been issued a letter of concern; or have you ever entered into a consent order or settlement agreement? ..... YES (NO)
   b) Is any disciplinary action pending against you? ..... YES (NO)
   c) Have you ever been denied a license or withdrawn an application for licensure? ..... YES (NO)

   If response is "yes," attach a detailed explanation on a separate sheet, which includes state or country where action is pending or took place, relevant dates, action taken and reasons for such action.

2) In the past two years, with regard to any educational training program or facility, state/federal controlled substance agency, local, state, federal or military professional or disciplinary body or any hospital privileging or credentialing body, grievance committee or any other medical group, including medical societies and specialty boards:
   a) Have you ever been subject to disciplinary or adverse actions or entered into an agreement? ..... YES (NO)
   b) Is any disciplinary or adverse action pending against you? ..... YES (NO)
   c) Have you ever been denied or withdrawn an application for privileges or membership, or have you ever resigned, surrendered or failed to renew your privileges or membership? ..... YES (NO)

   If response is "yes," attach a detailed explanation on a separate sheet, which includes the bodies of jurisdiction or organizations involved, relevant dates, action taken and reasons for such action.

3) In the past two years with regard to professional liability, participation in any health plan or Federal or State health care program:
   a) Have any claims of malpractice ever been filed against you? ..... (YES) NO
   b) Has any insurance carrier ever denied, conditioned, curtailed, limited, suspended or revoked your coverage? ..... YES (NO)
   c) Have you ever relinquished participation or certification, or been denied, terminated, sanctioned, penalized, decertified or otherwise excluded from participation? ..... YES (NO)
   d) Have you ever been convicted of insurance fraud? ..... YES (NO)

   If response is "yes," attach a detailed explanation on a separate sheet, which:
   - *Includes the date of the case (month/year), jurisdiction (State, etc.), nature of the case, allegations, and amount paid on your behalf. Information is to be provided on all settlements, judgments, awards, and claims (including those for which no money was paid); and/or*
   - *Provides the name and address of your insurance carrier, specific circumstances, date and action taken.*

4) In the past two years, have you been addicted to, dependent on, or a habitual user of alcohol or of a narcotic, barbiturate, amphetamine, hallucinogen, or other drug having similar effects? ..... YES (NO)

   If response is "yes," attach a detailed explanation on a separate sheet.

5) During the past two years, have you been convicted of a crime in which the conviction has not been annulled or expunged? ..... YES (NO)

   Explain "yes" response on a separate sheet with detailed information and attach supporting documents.

JUN 2 6 2008

1968-4
Of Counsel:
BURKE McPHEETERS BORDNER & ESTES

WILLIAM A. BORDNER 1371-0
Suite 3100 - Mauka Tower
Pacific Guardian Center
737 Bishop Street
Honolulu, Hawaii 96813
Telephone No. (808) 523-9833
Fax No. (808) 528-1656

Attorney for Defendants
HAWAI'I RESIDENCY PROGRAMS, INC.;
STEFANIE MASAKO UEDA, M.D.;
ROBERT BRYAN MURPHY, M.D.;
LEANNE MAYUMI KON, M.D.; and
NAOMI CHO AKITA, M.D.

FIRST CIRCUIT COURT
STATE OF HAWAII
FILED

2008 JUN 25 PM 12:13

F. OTAKE
CLERK

2008 JAN 14 A 10:56

IN THE CIRCUIT COURT OF THE FIRST CIRCUIT

STATE OF HAWAII

GERLA MONIZ and MATTHEW MONIZ,

Plaintiffs,

vs.

THE QUEEN'S MEDICAL CENTER, a Hawaii non-profit corporation; WILLIAM J. PARKER, M.D., also known as WILLIE PARKER, M.D. and WILLIE J. PARKER, M.D., M.P.H., individually and in his capacity as Assistant Professor of the John A. Burns School of Medicine, College of Health Sciences and Social Welfare, University of Hawai'i; MARK K. Y. HIRAOKA, M.D., individually and in his capacity as Assistant Professor of the John A. Burns School of Medicine, College of Health Sciences and Social Welfare, University of Hawai'i; HAWAII RESIDENCY

CIVIL NO. 06-1-1881-10 (BIA)
(Medical Malpractice)

STIPULATION FOR PARTIAL DISMISSAL WITH PREJUDICE OF PLAINTIFFS' CLAIMS AGAINST Defendants (1) WILLIAM J. PARKER, M.D., also known as WILLIE PARKER, M.D. and WILLIE J. PARKER, M.D., M.P.H., individually and in his capacity as Assistant Professor of the John A. Burns School of Medicine, College of Health Sciences and Social Welfare, University of Hawai'i; (2) MARK K. Y. HIRAOKA, M.D., individually and in his capacity as assistant professor of the John A. Burns School of Medicine, College of Health Sciences and Social Welfare, University of Hawai'i; (3) STEFANIE MASAKO UEDA, M.D. also known as STEFANIE MASAKO UEDA,

PROGRAMS, INC., a Hawaii non-profit corporation; STEFANIE MASAKO UEDA, M.D. also known as STEFANIE MASAKO UEDA, M.D.R.; ROBERT BRYAN MURPHY, M.D. also known as ROBERT BRYAN MURPHY, M.D.R.; LEANNE MAYUMI KON, M.D., also known as LEANNE MAYUMI KON, M.D.R.; NAOMI CHO AKITA, M.D. formerly known as NAOMI CHO AKITA, M.D.R.; JOAN A. KENDALL, M.D.; UNIVERSITY OF HAWAII, as body corporation; DOE INDIVIDUALS 1-10; DOE ENTITIES 1-10; DOE CORPORATIONS 1-10; DOE PARTNERSHIPS 1-10; DOE LIMITED LIABILITY PARTNERSHIPS 1-10; DOE LIMITED LIABILITY COMPANIES 1-10; DOE NON-PROFIT ORGANIZATIONS 1-10; and DOE GOVERMENTAL ENTITIES AND/OR AGENCIES 1-10,

Defendants.

M.D.R.; (4) ROBERT BRYAN MURPHY, M.D. also known as ROBERT BRYAN MURPHY, M.D.R.; (5) LEANNE MAYUMI KON, M.D., also known as LEANNE MAYUMI KON, M.D.R.; (6) NAOMI CHO AKITA, M.D. formerly known as NAOMI CHO AKITA, M.D.R.; (7) JOAN A. KENDALL, M.D.; and (8) UNIVERSITY OF HAWAII, a body corporate

TRIAL DATE: September 21, 2009

STIPULATION FOR PARTIAL DISMISSAL WITH PREJUDICE OF PLAINTIFFS' CLAIMS AGAINST DEFENDANTS (1) WILLIAM J. PARKER, M.D., also known as WILLIE PARKER, M.D. and WILLIE J. PARKER, M.D., M.P.H., individually and in his capacity as Assistant Professor of the John A. Burns School of Medicine, College of Health Sciences and Social Welfare, University of Hawai`i; (2) MARK K. Y. HIRAOKA, M.D., individually and in his capacity as Assistant Professor of the John A. Burns School of Medicine, College of Health Sciences and Social Welfare, University of Hawai`i; (3) STEFANIE MASAKO UEDA, M.D. also known as STEFANIE MASAKO UEDA, M.D.R.; (4) ROBERT BRYAN MURPHY, M.D. also known as ROBERT BRYAN MURPHY, M.D.R.; (5) LEANNE MAYUMI KON, M.D., also known as LEANNE MAYUMI KON, M.D.R.; (6) NAOMI CHO AKITA, M.D. formerly known as NAOMI CHO AKITA, M.D.R.; (7) JOAN A. KENDALL, M.D.; and (8) UNIVERSITY OF HAWAII, a body corporate

Pursuant to Hawaii Rules of Civil Procedure, Rule 41(a)(1)(B), Plaintiffs GERLA MONIZ and MATTHEW MONIZ and Defendants THE QUEEN'S MEDICAL CENTER, a Hawaii non-profit corporation; WILLIAM J. PARKER, M.D., also known as WILLIE PARKER, M.D. and WILLIE J. PARKER, M.D., M.P.H., individually and in his capacity as Assistant Professor of the John A. Burns School of Medicine, College of Health Sciences and Social Welfare, University of Hawai`i; MARK K. Y. HIRAOKA, M.D., individually and in his capacity as Assistant Professor of the John A. Burns School of Medicine, College of Health Sciences and Social Welfare, University of Hawai`i; HAWAII RESIDENCY PROGRAMS, INC.; STEFANIE MASAKO UEDA, M.D. also known as STEFANIE MASAKO UEDA, M.D.R.; ROBERT BRYAN MURPHY, M.D. also known as ROBERT BRYAN MURPHY, M.D.R.; LEANNE MAYUMI KON, M.D., also known as LEANNE MAYUMI KON, M.D.R.; NAOMI CHO AKITA, M.D. formerly known as NAOMI CHO AKITA, M.D.R.; JOAN A. KENDALL, M.D.; and UNIVERSITY OF HAWAII, a body corporate, hereby stipulate that all claims by

Plaintiffs asserted in the First Amended Complaint, filed on July 3, 2007, against Defendants WILLIAM J. PARKER, M.D., also known as WILLIE PARKER, M.D. and WILLIE J. PARKER, M.D., M.P.H., individually and in his capacity as Assistant Professor of the John A. Burns School of Medicine, College of Health Sciences and Social Welfare, University of Hawai'i; MARK K. Y. HIRAOKA, M.D., individually and in his capacity as Assistant Professor of the John A. Burns School of Medicine, College of Health Sciences and Social Welfare, University of Hawai'i; STEFANIE MASAKO UEDA, M.D. also known as STEFANIE MASAKO UEDA, M.D.R.; ROBERT BRYAN MURPHY, M.D. also known as ROBERT BRYAN MURPHY, M.D.R.; LEANNE MAYUMI KON, M.D., also known as LEANNE MAYUMI KON, M.D.R.; NAOMI CHO AKITA, M.D. formerly known as NAOMI CHO AKITA, M.D.R.; JOAN A. KENDALL, M.D.; and UNIVERSITY OF HAWAII, a body corporate, are hereby dismissed with prejudice.

The First Amended Cross-Claim against Defendants filed by Defendant JOAN A. KENDALL, M.D. on December 14, 2007 was disposed of by Defendant Kendall's Notice of Dismissal Without Prejudice of Defendant Joan A. Kendall, M.D.'s First Amended Cross-Claim Against Defendants The Queen's Medical Center, William J. Parker, M.D., aka Willie Parker, M.D. and Willie J. Parker, M.D., M.P.H., Mark K. Hiraoka, M.D., Hawaii Residency Programs, Inc.; Stefanie Masako Ueda, M.D., aka Stefanie Masako Ueda, M.D.R.; Robert Bryan Murphy, M.D., aka Robert Bryan Murphy, M.D.R.; Leanne Mayumi Kon, M.D. aka Leanne Mayumi Kon, M.D.R.; Naomi Cho Akita,

M.D., fka Naomi Cho Akita, M.D.R.; University of Hawaii; Doe Individuals 1-10; Doe Entities 1-10; Doe Corporations 1-10; Doe Partnerships 1-10; Doe Limited Liability Partnerships 1-10; Doe Limited Liability Companies 1-10; Doe Non-Profit Organizations 1-10 and Doe Governmental Entities and/or Agencies 1-10 Filed Herein On December 14, 2007, filed on March 18, 2008.

The only remaining claims are those claims brought in the First Amended Complaint filed by Plaintiffs on July 3, 2007 against Defendants THE QUEEN'S MEDICAL CENTER and HAWAII RESIDENCY PROGRAMS, INC.

Each party to this Stipulation shall bear his, her or its own fees and costs.

DATED: Honolulu, Hawaii, June 24, 2008

DONALD E. FISHER
Attorney for Plaintiffs

THOMAS E. COOK
JEFFREY A. GRISWOLD
Attorneys for Defendant
JOAN A. KENDALL, M.D.

JOHN S. NISHIMOTO
DAVID A. GRUEBNER
Attorneys for Defendants
THE QUEEN'S MEDICAL CENTER, WILLIAM J. PARKER, M.D., aka WILLIE PARKER, M.D. and WILLIE J. PARKER, M.D., and MARK HIRAOKA, M.D.

WILLIAM A. BORDNER
Attorney for Defendants
HAWAII RESIDENCY PROGRAMS, INC., STEFANIE MASAKO UEDA, M.D., ROBERT BRYAN MURPHY, M.D., LEANNE KON, M.D., and NAOMI CHO AKITA, M.D.

KENNETH S. ROBBINS
JOHN-ANDERSON L. MEYER
SERGIO RUFO
Attorneys for Defendant
UNIVERSITY OF HAWAII, a body corporate

Gerla Moniz and Matthew Moniz vs. The Queen's Medical Center, et al.
Civil No. 06-1-1881-10 (BIA)
In the Circuit Court of the First Circuit, State of Hawaii

STIPULATION FOR PARTIAL DISMISSAL WITH PREJUDICE OF PLAINTIFFS' CLAIMS AGAINST DEFENDANTS (1) WILLIAM J. PARKER, M.D., also known as WILLIE PARKER, M.D. and WILLIE J. PARKER, M.D., M.P.H., individually and in his capacity as Assistant Professor of the John A. Burns School of Medicine, College of Health Sciences and Social Welfare, University of Hawai'i; (2) MARK K. Y. HIRAOKA, M.D., individually and in his capacity as assistant professor of the John A. Burns School of Medicine, College of Health Sciences and Social Welfare, University of Hawai'i; (3) STEFANIE MASAKO UEDA, M.D. also known as STEFANIE MASAKO UEDA, M.D.R.; (4) ROBERT BRYAN MURPHY, M.D. also known as ROBERT BRYAN MURPHY, M.D.R.; (5) LEANNE MAYUMI KON, M.D., also known as LEANNE MAYUMI KON, M.D.R.; (6) NAOMI CHO AKITA, M.D. formerly known as NAOMI CHO AKITA, M.D.R.; (7) JOAN A. KENDALL, M.D.; and (8) UNIVERSITY OF HAWAII, a body corporate

Case Summary: Willie J. Parker MD, MPH

GERLA MONIZ and MATTHEW MONIZ,Plaintiffs vs THE QUEEN'S MEDICAL CENTER, WILLIE PARKER, M.D.,and MARK K. Y. HIRAOKA, M.D.
Civil No. 06-1-1881-10 BIA (Medical Malpractice) IN THE CIRCUIT COURT OF THE FIRST CIRCUIT STATE OF HAWAII

Case filed in 2005. Plaintiffs are alleging that I, as one of a team of doctors who cared for Ms. Moniz, and the Medical Center were negligent in failing to supervise resident physicians in her care, resulting in wrongful interruption of an early viable pregnancy. Patient was counseled that she had miscarried and was offered options and counseling.based on a verbal report of sonographic findings that conflicted with a written report later discovered. She elected management that resulted in disruption of the pregnancy. Dispute regarding what information was communicated regarding the sonographic findings by Resident physicians and the radiologist of record has resulted in the case proceeding to the discovery phase of the legal process. To date, interrogatories have been collected and depositions are potentially pending. My role involves being one of the attending physicians in supervision of the residents.

In August , 2008, I was dismissed with prejudice from the case settlement occurred on behalf Hawaii Residency Program and Queens Medical Center

Application for License : PHYSICIAN or GOVERNMENT EMPLOYED PHYSICIAN

Read instructions and requirements on attached sheet before completing this form.

Effective Date: 10-10-01 License No.: 11733

POSTED OCT 12 2001

FOR OFFICE USE ONLY

00525421	13-10/11/01	45.00
00525420	13-10/11/01	75.00
323 00525419	13-10/11/01	50.00

Name (First-Middle)	(Last)
WILLIE	PARKER

Residence Address (include apt., no., city, state and zip code): [redacted]

Mailing Address (if different from above): [redacted]

Social Security #: [redacted] Phone: [redacted]

Birthplace (city/state/country)	Birth date:	Date AMA profile requested:
[redacted]	Age: [redacted]	8/30/01

Circle or underline answers and explain if needed:

1) Are you at least 18 years of age? ..... (YES) NO
2) Are you a U.S. citizen, a U.S. national, or an alien authorized to work in the United States? ..... (YES) NO
3) Are you a graduate of a medical school whose M.D. program is accredited by the Liaison Committee on Medical Education, and have you attached evidence of completion? ..... (YES) NO
4) Have you attached evidence of residency of at least one year in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME)? ..... (YES) NO
5) Have you ever held a license in Hawaii? ..... YES (NO)
If response "yes," specify type of license and dates below.
6) Has any medical license to practice in any state or country ever been revoked, suspended or otherwise subject to disciplinary action? ..... YES (NO)
If response "yes," specify state where action took place, Penalty imposed and reasons for such action on a separate sheet.
7) Are you presently being investigated or is any disciplinary action presently pending against you? ..... YES (NO)
If response "yes," specify state where action is Pending and reasons on a separate sheet.
8) Are you aware of any derogatory information about you in the file of any state licensing agency? ..... YES (NO)
If response "yes," specify state where action is Pending and reasons on a separate sheet.
9) In the past twenty years, have you been convicted of a crime in which the conviction has not been annulled or expunged? ..... YES (NO)
If response "yes," provide information on the date, place and type of conviction on a separate sheet.

Check LICENSE CATEGORY you are applying for:

MD (X) REGULAR license *(NB, FLEX, or USMLE or NB & USMLE combination)*

Circle EXAM taken: NATIONAL BOARD (FLEX) USMLE SPEX

G ( ) GOVERNMENT *(will be employed by Hawaii state or county government agency)*

FOR COMPLETION ONLY BY GRADUATES OF MEDICAL SCHOOLS OTHER THAN IN U.S. OR CANADA:

Circle or underline answers. *Explain 'no' responses on separate sheet.*

Do you hold either of the following two certificates?
Educational Council for Foreign Medical Graduates (ECFMG) (current) Certificate? ..... YES (NO)
Fifth Pathway certificate? ..... YES (NO)

Have you completed at least 2 years of medical training in an internship or residency program approved by the ACGME and have you attached your evidence? ..... (YES) NO

LIST ALL LICENSES

Name of State(s)	Date Issued	License Number	Date 'Verification of License - MD' form Mailed to state:	Date 'Federation Discipline Report' mailed to Federation:
California	5/24/94	A65302	9/01/01	9/1/01
Iowa	3/19/92	28574	9/01/01	9/1/01
OHIO	5/29/92	35-063458	9/01/01	9/1/01

(Continued on Back)

RECEIVED PVL 2001 OCT 10 A 11:13 LICENSING BRANCH

End:	App/Lic	323/312	150/175	
Gov:	App/Lic	323/312	125/150	
	CRF	C13	145/170	
	½ Ran	300	0.75	
	Service Fee	BCF	0.15	

MD-01 0601

VERIFICATION OF LICENSE - PHYSICIAN

Access this form via website at: www.state.hi.us/dcca/pvl

OHIO STATE MEDICAL BOARD

SEP 12 2001

State of Hawaii
Board of Medical Examiners

APPLICANT

Name (First-Middle) WILLIE JAMES (LAST) PARKER

Social Security No. [redacted]

Address (include apt. no. and zip code) [redacted]12

LICENSE NUMBER 35-063458-P

DATE ISSUED 5/29/92

I hereby authorize the licensing agency of the state of OHIO to furnish the information below to the State of Hawaii Board of Medical Examiners.

Date 9/1/01 SIGN HERE [signature] MD, MPH

LICENSING AGENCY

This is to certify that the above-named individual was issued license number 63458

to practice medicine on the basis of:

- [ ] National Board Exam
- [ ] Nat'l Bd & USMLE
- [ ] FLEX exam - Prior to 1985
- [X] FLEX exam - After 1984
- [ ] USMLE
- [ ] state-constructed exam: (date passed: _____)
- [X] endorsement from: Ohio (2004) IA

Date issued: 5/29/92
Date license

expires: 9/30/96

License status: Suspended for Non Payment of Renewal Fees
- [ ] current
- [X] lapsed since: 9/30/96
- [ ] inactive since: _____

Has this license ever been encumbered in any way (revoked, suspended, surrendered, limited, placed on probation, currently pending disciplinary action being investigated)?..... [X] NO [ ] YES (Explain a yes response)

EXAMINATION SCORES

FLEX	Prior to 1985	CLINICAL COMPETENCE AVERAGE:	FLEX WEIGHTED AVERAGE:
	After 1984	COMPONENT 1	COMPONENT 2
NBME	Part 1	Part 2	Part 3
USMLE	Step 1	Step 2	Step 3

Exam Date(s):

Exam Location(s):

RECEIVED PVL LICENSING BRANCH HONOLULU SEP 24 A 10:50 DEPT OF COMMERCE & CONSUMER AFFAIRS STATE OF HAWAII

Signature: Debra L. Jones

Title: Debra L. Jones, Chief CME, Records & Renewal

State: Ohio State Medical Bd

Date: 9/13/01

BOARD SEAL

TO THE BOARD: Return this form directly to the Hawaii Board of Medical Examiners at the address below:

Board of Medical Examiners
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

MD-03 0801

VERIFICATION OF LICENSE PHYSICIAN

Access this form via website at: www.state.hi.us/dcca/pvl

40 [redacted] MD

State of Hawaii
Board of Medical Examiners

APPLICANT

Name (First-Middle) (LAST): WILLIE JAMES PARKER

Address (Include [redacted])

Social Security No.: [redacted]

LICENSE NUMBER: 28574

DATE ISSUED: 3/19/92

I hereby authorize the licensing agency of the state of IOWA to furnish the information below to the State of Hawaii Board of Medical Examiners.

Date 9/1/01 SIGN HERE [signature] MD, MPH

LICENSING AGENCY

This is to certify that the above-named individual was issued license number _____

to practice medicine on the basis of:

- [ ] National Board Exam
- [ ] Nat'l Bd & USMLE
- [ ] FLEX exam - Prior to 1985
- [X] FLEX exam - After 1984
- [ ] USMLE
- [ ] state-constructed exam: (date passed: _____)
- [ ] endorsement from: _____

Date issued: _____
Date license expires: _____

License status:
- [ ] current
- [ ] lapsed since: _____
- [ ] inactive since: _____

Has this license ever been encumbered in any way (revoked, suspended, surrendered, limited, placed on probation, currently pending disciplinary action being investigated)?
- [ ] NO
- [ ] YES (Explain a yes response)

EXAMINATION SCORES

FLEX	Prior to 1985	CLINICAL COMPETENCE AVERAGE:	FLEX WEIGHTED AVERAGE:
	After 1984	COMPONENT 1	COMPONENT 2
NBME	Part 1	Part 2	Part 3
USMLE	Step 1	Step 2	Step 3

Exam Date(s):

Exam Location(s):

RECEIVED PVL LICENSING BRANCH
2001 SEP 20 A 10:46
DEP OF COMMERCE & CONSUMER AFFAIRS
STATE OF HAWAII

Signature: _____

Title: _____

State: _____

Date: _____

BOARD SEAL

TO THE BOARD: Return this form directly to the Hawaii Board of Medical Examiners at the address below:

Board of Medical Examiners
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

MD-03 0601

VERIFICATION OF LICENSE - PHYSICIAN

Access this form via website at: www.state.hi.us/dcca/pvl

00993

State of Hawaii
Board of Medical Examiners

RECEIVED
MEDICAL BOARD
CALIFORNIA
01 SEP 10 PM 2:59

RECEIVED
01 SEP 10 PM 4:28

APPLICANT

Name (First-Middle) WILLIE JAMES (LAST) PARKER

Social Security No. [redacted]

Address (include apt. no. and zip code) [redacted]

LICENSE NO. A 053102

DATE ISSUED 05/25/94

I hereby authorize the licensing agency of the state of CALIFORNIA to furnish the information below to the State of Hawaii Board of Medical Examiners.

Date 9/1/01 SIGN HERE [signature] MD, MPH

LICENSING AGENCY

This is to certify that the above-named individual was issued license number _____

to practice medicine on the basis of:

- [ ] National Board Exam
- [ ] Nat'l Bd & USMLE
- [ ] FLEX exam - Prior to 1985
- [X] FLEX exam - After 1984
- [ ] USMLE
- [ ] state-constructed exam: (date passed: _____)
- [ ] endorsement from: _____

Date issued: _____

Date license expires: _____

License status:

- [ ] current
- [ ] lapsed since: _____
- [ ] inactive since: _____

Has this license ever been encumbered in any way (revoked, suspended, surrendered, limited, placed on probation, currently pending disciplinary action being investigated)?..... [ ] NO [ ] YES (Explain a yes response)

EXAMINATION SCORES

FLEX	Prior to 1985	CLINICAL COMPETENCE AVERAGE:	FLEX WEIGHTED AVERAGE:
	After 1984	COMPONENT 1	COMPONENT 2
NBME	Part 1	Part 2	Part 3
USMLE	Step 1	Step 2	Step 3

Exam Date(s):

Exam Location(s):

RECEIVED PVL LICENSING BRANCH
2001 SEP 20 A 10:47
DEPT OF COMMERCE & CONSUMER AFFAIRS
STATE OF HAWAII

Signature: _____

Title: _____

State: _____

Date: _____

BOARD SEAL

TO THE BOARD: Return this form directly to the Hawaii Board of Medical Examiners at the address below:

Board of Medical Examiners
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

MD-03 0601

STATE AND CONSUMER SERVICES AGENCY GRAY DAVIS, Governor

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 HOWE AVE, SUITE 58
SACRAMENTO CA 95825-3236
TELEPHONE: (916) 263-2382
FAX: (916) 263-2944

www.medbd.ca.gov

September 14, 2001

HAWAII BOARD OF MEDICAL EXAMINERS
DCCA, PVL LICENSING BRANCH
PO BOX 3469
HONOLULU HI 96801

To Whom It May Concern:

In response to your inquiry a standard search of available records in this office has been performed. The following indicates the results of that search:

Physician:	WILLIE JAMES PARKER
License No.:	A 53102
Issued:	May 25, 1994
Exam Type:	A written examination
Expiration Date:	October 31, 2001
Status:	Renewed/current

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2001 SEP 20 A 10:47
DEPT OF COMMERCE & CONSUMER AFFAIRS STATE OF HAWAII

If a discipline status is listed, you may obtain information concerning this action by contacting the Board's Enforcement Program, Central File Room, 1426 Howe Avenue, Sacramento, CA 95825-3236 or by faxing your request to the Central File Room at (916) 263-2420.

Lucinda James
Acting Chief, Division of Licensing

SEAL

STATE OF IOWA

THOMAS J. VILSACK
GOVERNOR
SALLY J. PEDERSON
LT. GOVERNOR

BOARD OF MEDICAL EXAMINERS
ANN E. MOWERY, PHD, EXECUTIVE DIRECTOR

September 13, 2001

Hawaii Board of Medical Examiners
DCCA, PVL Licensing, P.O. Box 3469
Honolulu, HI 96801

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

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

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

Sincerely,

Pat Town

Pat Town
Licensing Section
Iowa Board of Medical Examiners

HOSPITAL AFFILIATION – PHYSICIAN

Access this form via website at: www.state.hi.us/dcca/pvl

TO THE APPLICANT: Complete the *"Applicant"* section of this form. Send a form to each hospital where you have held, or applied for, privileges, consultation or teaching appointments or served in an internship or residency during any part of the most recent 3 years preceding your application for a physician's license in Hawaii. Your residency program director may complete this form in place of each hospital's administrator. If more than one form is needed, please duplicate both sides.

APPLICANT

Name (First-Middle) (LAST)	Social Security No.	Birthdate
WILLIE JAMES PARKER	[redacted]	

Date Served/Applied:	Capacity Served or Applied for	Name of Hospital/Residency Program
7/94 - 6/97	Staff Physician	Mercy Hospital + Health Svcs

To: CHIEF OF STAFF, ADMINISTRATOR OF HOSPITAL OR RESIDENCY PROGRAM DIRECTOR

I am applying for a license to practice medicine and surgery in Hawaii. The board requires this form be completed by the Chief of Staff or Administrator in each hospital where I have held, or applied for, privileges, consultation or teaching appointments or served in an internship or residency. For my residency program, the program director may complete this form. This request relates to a background investigation that must be completed prior to my being considered for a Hawaii license.

This is your authority to release any information, files, or records, favorable or otherwise, requested by the Hawaii State Board of Medical Examiners in connection with my application. Please complete the following questionnaire and PLEASE SUPPLY COPIES OF INFORMATION IN YOUR RECORDS that would provide further information and return the material directly to the address on the reverse side.

Date 8/30/01

WJ Parker MD, MPH
Signature of Applicant

CHIEF OF STAFF or ADMINISTRATOR OF HOSPITAL

NOTE: This form will be used to evaluate the past conduct and competency of the applicant. Any derogatory information reported on this form may, out of necessity, be shared with the applicant so that the applicant may respond to that information.

ALL QUESTIONS MUST BE ANSWERED.

A. POSTGRADUATE TRAINING:
1. Is the applicant, or has the applicant been engaged in postgraduate training in your program? ..... YES (NO)
2. Briefly evaluate applicant's competence and conduct during the program: N/A
3. Has the program ever had cause to restrict, suspend, terminate, or ask for a voluntary resignation of applicant's participation in the program? ..... YES NO
If response "yes," please explain and attach copies of material from your records: N/A

B. HOSPITAL PRIVILEGES:
1. Were privileges extended to the applicant? ..... (YES) NO
2. Please give start and end dates; and describe privileges: 1-20-95 to 1-22-98
3. Was applicant rejected privileges? ..... YES (NO)
If response "yes," please explain and attach copies of material from your records:
4. Were privileges ever limited, revoked, suspended or restricted? ..... YES (NO)
If response "yes," please explain and attach copies of material from your records:

C. SAFE PRACTICE COMMENTS:
1. Is there anything in your files which could call into question applicant's ability to safely practice medicine? ..... YES (NO)
If response "yes," please explain:
2. Derogatory information, if any: None

RECEIVED PVL LICENSING BRANCH
2001 SEP 10 A 10:11
DEPT OF COMMERCE & CONSUMER AFFAIRS STATE OF HAWAII

(CONTINUED ON BACK)

MD-08 0601

PLEASE SUPPLY ANY COPIES OF INFORMATION IN YOUR RECORDS THAT WOULD PROVIDE FURTHER INFORMATION AND SEND TO:

Board of Medical Examiners
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

Date 9/7/01

Signature of Chief of Staff, Administrator or Program Administrator

None

HOSPITAL/PROGRAM SEAL
(If none, please so indicate.)

Name Deborah Morton
Title Director Medical Staff
Hospital/Residency Program Mercy Medical Center
Address 2740 M Street
Merced CA 95340
Phone No. 209 384-6500

HOSPITAL AFFILIATION – PHYSICIAN

Access this form via website at: www.state.hi.us/dcca/pvl

TO THE APPLICANT: Complete the *"Applicant"* section of this form. Send a form to each hospital where you have held, or applied for, privileges, consultation or teaching appointments or served in an internship or residency during any part of the most recent 3 years preceding your application for a physician's license in Hawaii. Your residency program director may complete this form in place of each hospital's administrator. If more than one form is needed, please duplicate both sides.

APPLICANT

*Name (First-Middle)	(LAST)	Social Security No.	Birthdate
WILLIE JAMES	Parker	[redacted]	[redacted]

Date Served/Applied:	Capacity Served or Applied for	Name of Hospital/Residency Program
7/94 - 6/97	Staff Physician	Merced Comm. Medical Center

To: CHIEF OF STAFF, ADMINISTRATOR OF HOSPITAL OR RESIDENCY PROGRAM DIRECTOR

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Date 8/30/01 Parker MD, MPH

Signature of Applicant

CHIEF OF STAFF or ADMINISTRATOR OF HOSPITAL

NOTE: This form will be used to evaluate the past conduct and competency of the applicant. Any derogatory information reported on this form may, out of necessity, be shared with the applicant so that the applicant may respond to that information.

ALL QUESTIONS MUST BE ANSWERED.

A. POSTGRADUATE TRAINING:

1. Is the applicant, or has the applicant been engaged in postgraduate training in your program? ..... YES NO
2. Briefly evaluate applicant's competence and conduct during the program: _____
3. Has the program ever had cause to restrict, suspend, terminate, or ask for a voluntary resignation of applicant's participation in the program? ..... YES NO
   If response "yes," please explain and attach copies of material from your records: _____

B. HOSPITAL PRIVILEGES:

1. Were privileges extended to the applicant? ..... (YES) NO
2. Please give start and end dates; and describe privileges: 11/2/94 to 6/1/98 Ob/Gyn Dept.
3. Was applicant rejected privileges? ..... YES (NO)
   If response "yes," please explain and attach copies of material from your records: _____
4. Were privileges ever limited, revoked, suspended or restricted? ..... YES (NO)
   If response "yes," please explain and attach copies of material from your records: _____

C. SAFE PRACTICE COMMENTS:

1. Is there anything in your files which could call into question applicant's ability to safely practice medicine? ..... YES (NO)
   If response "yes," please explain: _____
2. Derogatory information, if any: _____

RECEIVED BRANCH HEEN STATE OF HAWAII SEP 24 A 10:51 DEPT. OF COMMERCE & CONSUMER AFFAIRS

(CONTINUED ON BACK)

PLEASE SUPPLY ANY COPIES OF INFORMATION IN YOUR RECORDS THAT WOULD PROVIDE FURTHER INFORMATION AND SEND TO:

Board of Medical Examiners
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

Date 9/19/01

Signature of Chief of Staff, Administrator or Program Administrator

Name _____

Title _____

HOSPITAL/PROGRAM SEAL
(If none, please so indicate.)

Hospital/Residency Program _____

Address _____

_____

Phone No. ( ) _____

The University of Iowa

ON THE RECOMMENDATION OF THE FACULTY OF THE

College of Medicine

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

Doctor of Medicine

UPON

Willie James Parker

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

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

Marvin A. Pomerantz
PRESIDENT OF THE STATE BOARD OF REGENTS

Hunter R. Rawlings III
PRESIDENT OF THE UNIVERSITY

John W. Eckstein
DEAN OF THE COLLEGE

University of Cincinnati Medical Center
University of Cincinnati Hospital

This is to certify that

WILLIE J. PARKER, M.D.

served as a

RESIDENT

in

OBSTETRICS & GYNECOLOGY

July 1, 1990 - June 30, 1994

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

Dean, College of Medicine

CEO/Director, University Hospital

Professor and Chairman, Department of Obstetrics and Gynecology