STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

DEPARTMENT OF LICENSING AND REGULATION

RAYMOND W. HOOD, SR., Director
P.O. Box 30018
Lansing, Michigan 48909
Telephone: (517) 373-1870

January 3, 1989

William H. Richardson, M.D.
1309 Pagly
Detroit,MI 48226

RE: MICHIGAN MEDICAL LICENSURE

DEAR DOCTOR:

This is to advise you that you have been issued a Michigan Medical licensure# 406168, dated December 19, 1988, and effective to January 31, 1990. You should expect to receive the Certificate of Licensure in four to six weeks. In the interim this letter will serve as your authority to practice medicine and apply for hospital staff privileges.

The engraved certificate of medical licensure will be ordered and forwarded to you when it has been obtained form the engraver, and the proper seal and signature affixed.

YOU ARE ADVISED TO KEEP THIS OFFICE INFORMED OF ANY CHANGE IN ADDRESS, WITHIN 30 DAYS OF THE CHANGE.

NOTE: IF YOU HAVE NOT APPLIED FOR YOUR CONTROLLED SUBSTANCE LICENSE PLEASE CONTACT THE MICHIGAN BOARD OF PHARMACY, P. O. BOX 30018, LANSING, MI 48909 (517) 373-0620.

PLEASE NOTE THE ENCLOSURES.

Sincerely Yours,

Florestine Beasley

Florestine Beasley
Board Secretary

(SEAL)

RECYCLED PAPER

DW 12/19/88 bb

AMOUNT PAID

NOV 29 88

LMD 340 (6/88)

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATION
BOARD OF MEDICINE
P.O. BOX 30018
LANSING, MICHIGAN 48909
(517) 373-0680

This form is required by P.A. 368 of 1978 in order for you to be licensed in Michigan.

APPLICATION FOR MEDICAL AND CONTROLLED SUBSTANCE LICENSES

I am applying for the following:

- [x] License by examination — Fee: $165.00
- [ ] License by endorsement — Fee: $105.00
- [ ] Controlled Substance license — Fee: $50.00

MEDICAL LICENSE APPLICATION

I am applying on the basis of the following examination:

- [ ] FLEX
- [x] NATIONAL BOARDS
- [ ] OTHER

NAME OF APPLICANT (last, first, middle)

RICHARDSON, WILLIAM, H

RECEIVED
DEPT. OF LIC. & REG.
BOARD OF MEDICINE

ADDRESS (no., street, city, state, zip)

1309 BAGLY, DETROIT, MICHIGAN, 48226

DATE OF BIRTH	SOCIAL SECURITY NUMBER
[redacted]	[redacted]

CHECK THE APPROPRIATE ANSWER TO EACH OF THE FOLLOWING QUESTIONS. ATTACH DETAILED EXPLANATION FOR ANY YES ANSWER YOU CHECK.

Have you ever been convicted of a crime?	[ ] YES	[x] NO
Have you ever been under treatment for addiction or insobriety?	[ ] YES	[x] NO
Are you now or have you ever been a defendant in a medical malpractice civil suit?	[ ] YES	[x] NO
Have you ever been refused a license to practice professionally for any reason by any state or federal agency?	[ ] YES	[x] NO
Have you ever been denied the privilege of taking an examination by any state medical board?	[ ] YES	[x] NO
Have you ever had your medical or controlled substance license, certificate, registration or approval revoked or suspended, or have you ever been otherwise disciplined by a medical board or a board responsible for regulating controlled substances?	[ ] YES	[x] NO
Do you currently have any charges or complaints pending against you before a medical board or a board responsible for regulating controlled substance?	[ ] YES	[x] NO
Have you ever held a restricted state or federal license, certificate, registration, or approval?	[ ] YES	[x] NO
Do you hold or have you ever held a medical license in another state? If yes, list each state and the date such license was issued:	[ ] YES	[x] NO

Provide a complete chronological record of all your educational preparation and work experience from secondary or high school to the present date, including all undergraduate clinical clerkships you completed. Attach additional sheets if necessary.

NAME AND ADDRESS OF INSTITUTION	DATES OF ATTENDANCE From	To	DEGREE OBTAINED
BENEDICTINE HIGH SCHOOL 8001 W OUTER DR DETROIT MI 48223	9/74	6/78	H.S.
UNIVERSITY MICHIGAN	9/79	6/82	B.S.
UNIVERSITY OF MICHIGAN MEDICAL SCHOOL	8/82	6/85	M.D.
HENRY FORD HOSPITAL OB/GYN RESIDENCY PROGRAM (DETROIT MI)	7/85	6/89	

I understand that it is the policy of the Department of Licensing and Regulation to secure conviction criminal history information as part of their pre-licensure screening process, and I authorize the department to use the information provided in this application to obtain a conviction criminal history file search from the Central Records Division of the Michigan Department of State Police. I hereby certify that the information in this application is true and correct and I hereby make application for medical licensure in Michigan.

Signature William N Richardson Date 11/5/88

Subscribed and sworn to before me this 6th day of NOVEMBER, 1988

Signature of Notary Public Valerie Richardson

County of Wayne My commission expires 8-7-1990

CONTROLLED SUBSTANCE LICENSE APPLICATION

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. A separate controlled substance license is required for each business location from which you manufacture, distribute, prescribe, or dispense controlled substances. If you will practice at an additional location or in a methadone program, please request in writing an Application for Additional Location from the Michigan Board of Pharmacy, P.O. Box 30018, Lansing, Michigan 48909.

Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 357 Federal Building, 231 Lafayette, Detroit, Michigan 48226 (Telephone 313-226-7290).

I hereby make application for a Michigan controlled substance license.

Signature William N Richardson MD Date 11/28/88

State of Michigan
Department of Licensing and Regulation
BOARD OF MEDICINE
P.O. Box 30018
Lansing, Michigan 48909

NOV 2 1 1988

CERTIFICATION OF MEDICAL EDUCATION FOR GRADUATES OF MEDICAL SCHOOLS LOCATED IN THE UNITED STATES, ITS TERRITORIES, THE DISTRICT OF COLUMBIA, OR THE DOMINION OF CANADA

APPLICANT INSTRUCTIONS

Complete Section I. Type or print your name exactly as it appears on your application. Send this form to the dean of the medical school you attended for completion of Section II. This certification must be submitted directly to the Michigan Board of Medicine by the medical school.

RECEIVED
NOV 2 1988
DEPT. OF LIC. & REG.
BOARD OF MEDICINE

SECTION I: APPLICANT INFORMATION

NAME OF APPLICANT (last, first, middle) RICHARDSON, WILLIAM H	
ADDRESS (no., street, city, state, zip) 1309 BARLEY DETROIT MI 48226	
DATE OF BIRTH [redacted]	SOCIAL SECURITY NUMBER [redacted]
DATE OF ADMISSION 6/78 (VIA INTERLOCK PROGRAM)	DATE OF GRADUATION 6/85

SECTION II: CERTIFICATION OF MEDICAL EDUCATION

NAME OF MEDICAL SCHOOL The University of Michigan Medical School
FULL ADDRESS OF MEDICAL SCHOOL Ann Arbor, Michigan 48109-0611

I certify that William Henry Richardson attended the medical school named above from September 4, 1980 through June 28, 1985 and was ~~XXXXXXXXX~~ granted the degree of Doctor of Medicine on June 28, 1985.

November 11, 1988
(Date)

Signature of Dean or Registrar

Carol A. Kauffman, MD-Assitant Dean for Student Affairs
Type or Print Name of Dean or Registrar

(S E A L)

NOTE: This certification must be returned by the medical school directly to the Michigan Board of Medicine at the address shown above.

(01/88)

State of Michigan
Department of Licensing and Regulation
BOARD OF MEDICINE
P.O. Box 30018
Lansing, Michigan 48909

RECEIVED
DEC -7 1988
DEPT OF LIC. & REG.

CERTIFICATION OF POSTGRADUATE TRAINING

APPLICANT INSTRUCTIONS

Complete Section I. Type or print your name exactly as it appears on your application. Send this form to the director of medical education of the hospital in which you completed your postgraduate training for completion of Section II.

SECTION I: APPLICANT INFORMATION	RECEIVED
NAME OF APPLICANT (last, first, middle) RICHARDSON, WILLIAM H	
ADDRESS (no., street, city, state, zip) 1309 BAGLEY DETROIT MI 48221	DEC 07 1988 DEPT. OF LIC. & REG. BOARD OF MEDICINE
DATE OF BIRTH [redacted]	SOCIAL SECURITY NUMBER [redacted]

SECTION II: HOSPITAL CERTIFICATION OF TRAINING

HOSPITAL NAME HENRY FORD HOSPITAL
HOSPITAL'S COMPLETE ADDRESS 2799 WEST GRAND BLVD; DETROIT MI 48202

I certify that WILLIAM H. RICHARDSON a graduate of the UNIVERSITY OF MICHIGAN medical school, has successfully completed postgraduate clinical training offered by the hospital named above from JULY 1 1985 through NOVEMBER 30 1988 in the clinical area of OBSTETRICS AND GYNECOLOGY.

11/28/88
(Date)

Signature of Director of Medical Education

Ronald T. Burkman
Type or Print Name of Director of Medical Education

Chair., Dept of Ob/Gyn

No seal
(SEAL)

Is this training program accredited by ACGME or by the national joint committee on accreditation of preregistration physician training programs of the Canadian medical association?

Yes ☒ No ☐

If hospital has no seal, please so indicate.

NOTE: Certification of postgraduate training will not be accepted if certified more than 15 days prior to actual completion.

(01/88)

NATIONAL BOARD OF MEDICAL EXAMINERS • • 3930 CHESTNUT STREET, PHILADELPHIA PENNA. 19104

ENDORSEMENT OF CERTIFICATION

NATIONAL BOARD OF MEDICAL EXAMINERS
OF THE
UNITED STATES OF AMERICA

William M. Richardson, M.D. ✓ **RECEIVED**

having satisfied all the requirements and having successfully passed the examinations is hereby declared a Diplomate of the National Board of Medical Examiners.

DEC 06 1988

DEPT. OF LIC. & REG.

Attest C. WILLIAM DAESCHNER, JR., M.D.
Chairman of the Board

SEAL EDITH J. LEONARD, M.D.
President of the Board

Philadelphia, Pa.

07/01/88 Certificate # 316121

It is certified that the above is a facsimile of the Diplomate Certificate which has been or will be* awarded to the physician named above, who graduated from U MICHIGAN MEDICAL SCHOOL in JUNE 1985 and whose birth date is [redacted] This physician has successfully completed all examinations required for certification by the National Board of Medical Examiners. The scores obtained by this physician upon which his/her certification is based are as follows:

	Standard Score	Scale Score
PART I passed 09/83		
Anatomy, incl. histology and embryology	[redacted]	[redacted]
Physiology		
Biochemistry		
Pathology		
Microbiology, incl. immunology		
Pharmacology and Materia Medica		
Behavioral Sciences		
TOTAL TEST (Minimum Passing Score 380/75)		
Part II passed 09/84		
Internal medicine and the medical specialties	[redacted]	[redacted]
Surgery and the surgical specialties		
Obstetrics and Gynecology		
Public Health and Preventive Medicine		
Pediatrics		
Psychiatry		
TOTAL TEST (Minimum Passing Score 290/75)		
PART III passed 03/86		
A General Test of Clinical Competence	[redacted]	[redacted]
TOTAL TEST (Minimum Passing Score 290/75)		
GENERAL AVERAGE (Parts, I, II, and III Scale Score)		[redacted]

*For those individuals who have not yet satisfactorily completed one full year of post-M.D. training the date shown on the facsimile is the date which has been certified by the physician's residency program director as the date on which this requirement for certification by the National Board will be fulfilled and such certification will be awarded.

Melanie Valente
Secretary for Certification

SEAL

12/02/88
Date

STATE OF MICHIGAN DEPARTMENT OF LICENSING & REGULATION
P.O. BOX 30018 LANSING, MI 48909

BOARD OF MEDICINE

EDUCATION/TRAINING LIMITED M.D.

RENEWAL FEE IF PAID BEFORE	7-1-86	$ 30.00
ADDITIONAL LATE FEE DUE AFTER	06-30-86	$ 20.00
TOTAL FEES DUE NOW ——→		$ 30.00

RENEWAL INSTRUCTIONS:

1. Postgraduate trainee completes ALL appropriate items below and on reverse side. The Director of Medical Education must complete all items on the right portion of reverse side. Postgraduate trainee is responsible for returning completed application in envelope provided.
2. Make check or money order payable to:
STATE OF MICHIGAN MEDICINE

4314 006168 24 003000 00 000000 23 302000 0 136 070029 0

RICHARDSON, WILLIAM H 82
HENRY FORD HOSP
2799 W GRAND BLVD
DETROIT MI 48202

OBSTETRICS/GYNECOLOGY
LICENSEE AND MEDICAL DIRECTOR
COMPLETE REVERSE SIDE

If you are in a different program than you were last year give new program name

Enter any personal name changes at right

ENTER ANY HOSPITAL NAME AND ADDRESS CHANGES BELOW

Hospital Name

Street Address

City State Zip County

Your current limited license expires on 6-30-96. You may renew both your limited license and your Controlled Substance license (if you have one) with this renewal card.

THIS SIDE TO BE COMPLETED BY POSTGRADUATE TRAINEE

Check One Box Below Which Describes Your Renewal Status

- [X] I am continuing my training beyond June 30, at the same location shown on reverse side
- [ ] I am continuing my training beyond June 30, but will transfer to a new location prior to or on June 30. Enter new program name and address in area below
- [ ] I will not continue my training beyond June 30

Terminated Date _____

Forwarded Address _____

THIS SIDE MUST BE COMPLETED, SIGNED AND SEALED BY THE DIRECTOR OF MEDICAL EDUCATION — CERTIFICATION OF TRAINING APPOINTMENT

LLG-222 (1/86)

This Certifies That William Richardson '99 Date Born
Print Name of Postgraduate Trainee

Appointed to the position of (check one box below and enter program name):

- [ ] Intern (MD only)
- [ ] Categorical First Year in (MD only) _____
- [ ] Flexible First Year in (MD only) _____
- [X] 2 3 4 5 (circle one) Year Resident in OB/Gyn

Hospital Name Henry Ford

Signature of Director of Medical Education

Date 4/28

HOSPITAL SEAL

FOR DEPOSIT ONLY
LICENSING AND REGULATION
STATE OF MICHIGAN

'24 9904005986 20 30.00

Printed Name of Director of Medical Education
DAVID LEACH, M.D.

S124-4

STATE OF MICHIGAN — DEPARTMENT OF LICENSING & REGULATION
P.O. BOX 30018 LANSING, MI. 48909

BOARD OF MEDICINE
EDUCATION/TRAINING LIMITED M.D.

RENEWAL FEE DUE ON OR BEFORE 6-30-87 $ 30.00

LATE FEES DUE AFTER 6-30-87 $ 20.00

TOTAL FEES DUE NOW → $ 30.00

4301 406168 24 003000 00 000000 23 002000 0 617 370010

WILLIAM H RICHARDSON
HENRY FORD HOSP
2799 W GRAND BLVD
DETROIT MI 48202

82

OBSTETRICS/GYNECOLOGY
LICENSEE AND MEDICAL DIRECTOR
COMPLETE REVERSE SIDE

© 12001

RENEWAL INSTRUCTIONS:

1. Make any changes below and on reverse side
2. ENTER ANY PERSONAL NAME CHANGES →
3. Make check or money order payable in U.S. currency to: STATE OF MICHIGAN (Do not send cash)

MEDICINE
6-30-87 CURRENT LICENSE EXPIRATION DATE

IF YOU ARE IN A DIFFERENT PROGRAM THAN LAST YEAR, GIVE NEW PROGRAM NAME →

ENTER ANY HOSPITAL NAME AND ADDRESS CHANGES

Hospital Name

Street Address

City State Zip Code County

LLC-240(10/86)

THIS SIDE TO BE COMPLETED BY POSTGRADUATE TRAINEE

Check One Box Below Which Describes Your Renewal Status

[X] I am continuing my training at the same location shown on reverse side.

[ ] I am continuing my training but will transfer to a new location and/or program.

[ ] I will not continue my training in Michigan beyond Aug 31

If you have not received above the expiration date of your license, 9/28/A.M.C., or amended, authorizes you to practice for a period of 60 days following expiration of what you may renew upon payment of the renewal fee and late fee.

If you fail to renew on or before the 60th day following license expiration date, your license will [illegible]

THIS SIDE MUST BE COMPLETED, SIGNED AND SEALED BY THE DIRECTOR OF MEDICAL EDUCATION — CERTIFICATION OF TRAINING APPOINTMENT

THIS CERTIFIES THAT POSTGRADUATE TRAINEE IDENTIFIED ON FRONT WAS APPOINTED TO GRADUATE MEDICAL EDUCATION OFFICE

HOSPITAL NAME HENRY FORD HOSPITAL

2799 W. GRAND BLVD

PROGRAM NAME DETROIT, MI 48202 -OB/GYN

SIGNATURE OF DIRECTOR

POST TO DEPOSIT ONLY
LICENSING AND REGULATION
STATE OF MICHIGAN

[illegible] 2002-070687 [illegible]

S 17691 B

LMD-060 (3/82)

State of Michigan
Department of Licensing & Regulation
BOARD OF MEDICINE
P.O. Box 30[illegible]8
Lansing, MI 48909

RECEIVED
JUN 06 1985
DEPT. OF LIC. & REG.
BOARD OF MEDICINE

MAY 31 7 8389693 ****38.60

Do not write in this space

APPLICATION FOR LIMITED LICENSE FOR POST-GRADUATE TRAINING IN AN APPROVED TRAINING HOSPITAL.

FEE: $30.00
Do not send cash.
Make check or money order in U.S. currency payable to
STATE OF MICHIGAN — MEDICINE

This is a sworn statement.

Name (last, first, middle)
Richardson, William, H.

Daytime Telephone Number
(313) 861-2688

Address (street and number, city, state, ZIP code)
19200 Warrington, Detroit, MI, 48221

Permanent Address or Address of Nearest Relative
same

Date of Birth
[redacted]

Citizenship
☒ U.S. ☐ Other (give visa status, date and number) _____

1. Have you ever been convicted of a felony or misdemeanor for which you could have gone to jail? (You may exclude traffic violations.)	☐ Yes	☒ No	If yes, do NOT give details at this time.
2. Have you ever had an adverse civil judgment (including malpractice)? (You may exclude divorce decrees.)	☐ Yes	☒ No	If yes, give details on a separate sheet.
3. Have you been examined by the National Board or any State Board of Medicine?	☐ Yes	☒ No	If yes give details.
4. Have you been certified by the Educational Council for Foreign Medical Graduates?	☐ Yes	☒ No	If yes, give certificate number: _____
5. Have you been certified by the Visa Qualifying Examination?	☐ Yes	☒ No	If yes, give certificate number: _____
6. Have you ever been denied a license to practice medicine?	☐ Yes	☒ No	If yes, give details.
7. Do you hold a license to practice medicine in any other states?	☐ Yes	☒ No	If yes, give states: _____

APPLICANT INSTRUCTIONS

1. No application will be accepted without proper completion of the educational and training certifications by the appropriate officials. This applies to all applicants without exception.
2. The application will not be accepted unless properly signed and sworn to by the applicant, notarized, and endorsed by the medical director or superintendent of the hospital in which you will train.
3. This application must be complete and on file in the offices of the Board of Medicine on or before July 1 of the year in which the permit is requested.
4. Intentional misstatements or omissions on this application may cause denial of a license, or, if a license was issued before discovery of the misrepresentation, a license may be revoked by the Board and the applicant subjected to prosecution.
5. Your fee should accompany this application and should be in the form of a check or money order. No responsibility is assumed for fees sent in any other manner.
6. Before issuance of the limited license, a personal appearance with your medical school diploma may be required.

This form is required by Public Act No. 368 of 1978, as amended, and must be submitted for you to be licensed.

8. CERTIFICATE OF DEAN, SECRETARY OR REGISTRAR OF MEDICAL COLLEGE

I hereby certify that I have reviewed the answers of this applicant. I certify that to the best of my knowledge all of the answers or statements are true and are a matter of official record in this school, and that said applicant is of good professional character.

I further certify that William Henry Richardson

matriculated in the University of Michigan Medical School is expected to
Name of medical school

graduate June 28, 1985 (Date), at which time the degree of Doctor of Medicine will be granted.
Date

If the degree, Bachelor of Medicine, is conferred upon completion of four years of medical school, further state the conditions and time the degree, Doctor of Medicine, will be granted.

DATED AT The University of Michigan

THIS 4th day of April, 1985

(SEAL)
Seal of college must be attached

Signature of Dean, Secretary or Registrar

University of Michigan Medical School
Name of medical college

1301 Catherine Rd., Ann Arbor, MI 48109-0010
Address of medical college

9. CERTIFICATE OF MEDICAL DIRECTOR OR SUPERINTENDENT OF MICHIGAN TRAINING HOSPITAL

This certifies that William Henry Richardson, M.D.

has been appointed to the position of ☒ CATEGORICAL 1st yr. in Obstetrics/Gynecology

☐ CATEGORICAL* 1st yr. in _____

☐ FLEXIBLE 1st yr. in _____

RESIDENT _____

In Henry Ford Hospital beginning 6/24/85
Name of Hospital

and ending 6/30/86

Signature of Medical Director or Superintendent

10. CERTIFICATION OF POSTGRADUATE TRAINING:

(*leave blank if this year of training has not been completed at the date the application is submitted)

I hereby certify that Dr. _____ satisfactorily

served a rotating internship in _____ Hospital.

from the _____ day of _____, 19 ____, to the _____ day of _____, 19 ____.

(Signed) _____
(Medical Director or Superintendent)

Date _____

_____
(Name of hospital)

(SEAL)

_____
(Address of hospital)

11. **EDUCATION AND TRAINING BACKGROUND**

	Name and Location of Institution	Dates of Attendance FROM (month, year)	TO (month, year)	Degree Earned
PREMEDICAL EDUCATION	UNIVERITY OF MICHIGAN			B.S.
	(INTERFLEX PROGRAM)			
MEDICAL EDUCATION (Submit Dates for Each School Year)	UNIVERSITY OF MICHIGAN	9/80	6/81	M.D. expected 6/28/85
		8/81	1/82	
		8/82	7/83	
		10/84 7/84	7/84 6/85	
POST GRADUATE EDUCATION				
INTERN-SHIP				Type: ☐ Rotating ☐ Mixed ☐ Straight

NOTE: Please attach a complete summary of your medical training and experience. Be sure to include information on any gaps in your training (military service, illness, other employment, literary degrees, etc.).

AFFIDAVIT

I, being duly sworn, depose and say that I am the applicant named in this application to practice medicine and surgery in Michigan under a limited license; that I have read the application and know the contents of it to be true; that I have not withheld any material fact from the Board of Medicine; that I understand intentional omissions or misrepresentations may subject me to disciplinary or criminal action; that the photograph attached is a true likeness of myself; and that I hereby agree to uphold the laws of the State of Michigan and the rules promulgated thereunder concerning the practice of medicine and surgery in this state.

Signature of Applicant William Richardson

Date of Signature 3/29/85

NOTARIZATION OF SIGNATURE

State of Michigan

County Wayne

Subscribed to and sworn before me, a Notary Public,

this 29th day of March, 19 85

Barbara Kartsonas

Signature of Notary Public

Barbara Kartsonas

February 28, 1989

My commission expires:

(SEAL)

FOR OFFICE USE ONLY

RECORD OF LIMITED LICENSES ISSUED

No. 1

Number 6168 for Henry Ford Hospital

Effective Date from ~~July 1, 19~~ 6-10-85 to June 30, 19 86
6/24/85

No. 2

Number _____ for _____ Hospital

Effective Date from July 1, 19 ____ to June 30, 19 ____

No. 3

Number _____ for _____ Hospital

Effective Date from July 1, 19 ____ to June 30, 19 ____

No. 4

Number _____ for _____ Hospital

Effective Date from July 1, 19 ____ to June 30, 19 ____

No. 5

Number _____ for _____ Hospital

Effective Date from July 1, 19 ____ to June 30, 19 ____