BEFORE THE
BOARD OF MEDICAL EXAMINERS
STATE OF OREGON

COPY

In the Matter of: DONALD WILLIS, M.D., LICENSE NO. MD10994.	)	VOLUNTARY LIMITATION

Donald Willis, M.D. is a physician licensed to practice medicine in the State of Oregon. Pursuant to the provisions of ORS 677.410, Dr. Willis requests that the Board of Medical Examiners (Board) impose the following conditions on his license to practice medicine in the State of Oregon:

(1) Dr. Willis will practice medicine only in a supervised setting approved by the Board in advance.

(2) Dr. Willis must undergo a neuropsychological examination at his expense to be reported to the Board of Medical Examiners beginning in July 1996 and continuing every two years thereafter, or sooner if deemed appropriate by the Board.

(3) Dr. Willis will arrange to have written reports from the Chief of Staff of his approved supervised setting, and his treating psychiatrist, to be sent to the Board at each of its quarterly meetings beginning in October 1994.

Dr. Willis understands and agrees that this voluntary limitation is subject to approval by the full Board. If Dr. Willis fails to abide by the conditions imposed herein, he understands and agrees that the Board may enter an order imposing disciplinary action to include revoking, suspending or otherwise sanctioning the license of Dr. Willis. Dr. Willis also

1 understands that, if this voluntary limitation is accepted by the
2 Board, it will be a reportable license limitation to the National
3 Practitioner Data Bank. This voluntary limitation also will be
4 reportable to any hospital or other institutional health care
5 provider at which Dr. Willis intends to practice, the Federation
6 of State Medical Boards, and, if requested by any person,
7 reportable as a public record.

8 IT IS SO STIPULATED this 9 day of Aug., 1994.

9

10 Donald C. Willis
Donald Willis, M.D.

11

12 IT IS SO ACCEPTED this 18th day of August, 1994.

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14 Terry Connor, D.O., Chairman
15 Board of Medical Examiners
State of Oregon

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26 PJS:cfs:ros/JGG09EAE

License Verification Details

SUBJECT TO TERMS AND CONDITIONS
Information current as of: 01/24/2017
Session: 2017-01-24 01:27:47.759 | 172.21.5.175 /neuwcnf12z3jskmvyn0jnw4q

This site is a primary source for verification of license credentials consistent with Joint Commission and NCQA standards.

Willis, Donald Clyde MD

Gender: Male

Year of Birth: 1943

Address Type	City	County	State	Phone
Practice	Apple Valley	San Bernardino	California	

License

Number: MD10994

License Type: MD License

Originally Issued: 01/13/1978

Current Status: Expired

Status Effective: 1/19/2006

Expedited Endorsement: No

Basis: NBME

Specialty : Obstetrics and Gynecology

Specialty is self-reported by the licensee. It does not necessarily indicate specialty board certification. Check directly with the Specialty Member Board for current certification status.

Education

School Name	Location	Degree Date	Degree Earned
IN UNIV SCH/MED	INDIANAPOLIS, IN United States	02/29/1976	MD

Post-Graduate Training	School Name	Location	From	To	Specialty
Residency	STANFORD UNIV MED CTR	STANFORD, CA United States	07/1977		
Internship	ROYAL JUBILEE HSP	VICTORIA, BC Canada	06/1976	06/1977	

The licensee may have completed additional education or training programs. Only those that have been verified with the primary source are shown.

Board Orders

Board Orders and Agreements are public records. Please note that Corrective Action Orders, Corrective Action Agreements, and Consent Agreements are not disciplinary and are removed from this website upon completion. Copies of any Orders or Agreements are available through a license verification request .

Effective Date	End Date	Order Type
08/18/1994	Open	Voluntary Limitation
	FOLLOW-UP CARE	

Malpractice

Malpractice claim information is compiled by the Oregon Medical Board from claim reports it receives from primary insurers; public bodies required to defend, save harmless and indemnify an officer, employee or agent of the public; a self-insured entity; or a health maintenance organization. Claim reporting and disclosure requirements are governed by ORS 742.400.

The settlement of a medical malpractice claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the provider. Therefore, there may be no disciplinary action appearing for a licensee, even though there is a closed malpractice claim on file. A payment in the settlement of a medical malpractice action does not create a presumption that medical malpractice occurred. This database represents information from reporters to date. Please note: Not all reporters may have submitted claim information to the Board.

For malpractice claim information, click here.

Oregon Medical Board
1500 SW 1st Ave, Suite 620
Portland, OR 97201
Phone: (971) 673-2700

Oregon

Kate Brown, Governor

Medical Board
1500 S.W. 1st Ave., Suite 620
Portland, OR 97201
Voice (971) 673-2700
FAX (971) 673-2670
www.oregon.gov/OMB

January 24, 2017

Citizens Information Center
PO Box 961216
Boston, MA 02196

Fax

REPORT NAME:	**INDIVIDUAL MALPRACTICE SEARCH**
REPORT SUBJECT:	**Donald Clyde Willis MD**
LICENSE #:	**MD10994**

The Oregon Medical Board is responding to your inquiry regarding the malpractice history for the above-referenced Licensee. Per ORS 742.400, malpractice information is provided to the Board from malpractice carriers and other self insured entities. The Board is permitted to release information about closed claims only.

The result of our database search is indicated below:

- Information about closed malpractice claims on file with the Oregon Medical Board for this Licensee is enclosed.

If you have questions regarding malpractice information or this letter, please contact the Board's Investigations Department at (971) 673-2696, or toll free in Oregon at (877) 275-6263.

Sincerely,

Angela Allen
Accounts Receivable Specialist

Enclosures

Oregon Medical Board
1500 SW 1st Avenue, Ste 620
Portland, Oregon 97201-5847
(971) 673-2700 • www.oregon.gov/omb

INDIVIDUAL MALPRACTICE REPORT

Malpractice claim information is compiled by the Oregon Medical Board from claim reports it receives from primary insurers; public bodies required to defend, save harmless and indemnify an officer, employee or agent of the public; self-insured entities; or health maintenance organizations. Claim reporting and disclosure requirements are governed by ORS 742.400.

LICENSEE / DEFENDANT

Licensee: Donald Clyde Willis MD **License #:** MD10994 **Birth Year:** 1943
Specialty: Obstetrics and Gynecology **License Status:** Expired **First Licensed:** 01/13/78

Practice Address: Us Family Care 18182 Outer Hwy 18 Apple Valley, CA 92307 **Practice Telephone #:**

INSURER

Insurer: Continental Casualty Company (CNA) – NAIC #20443 -
Claim ID#:48-221675 **Claim Reported to Insurer:** 10/13/86 **Claim Reported to Board:** 02/17/88

CLAIM

Claim Allegation: LAWSUIT. ARM LACERATION BY GLASS. ALLEGED NEGLIGENCE IN NOT REMOVING GLASS FRAGMENTS.

Injured Person's Gender: Female **Injured Person's Age:** 27 **Date of Injury:** 10/03/84
Plaintiff (if not injured Person): None Reported **Total Defendants Involved in Claim:** 1
Plaintiff Attorney: KELLEY BROWN - PORTLAND, OR
Institution Where Injury Occurred: TIGARD, OR
InstitutionType / Location: (5) Insured's Office - (99) Not Applicable
Severity of Injury: (2) Insignificant
Issues Related to Diagnosis: (3) Misdiagnosis in the absence of an abnormal condition
Issues Related to Procedures: A - (01) Not adequately indicated or unnecessary
Others Contributing to Injury: B - (99) Not Applicable
Associated Claim Issues: C - (99) Not Applicable.
Policy Coverage: (3) Policy covers all claims whenever presented for events which occur during the policy term.
Companion Claim(s) ID Number:

SETTLEMENT

Claim Closed: 02/02/88 **Claim Disposition:** (1) Settled by parties
Settlement Process: (3) During trial or hearing. **Review Panel:** (99) Not Applicable.
Court Decision: (0) No court proceedings were initiated. **Binding Arbitration:** N/A

	Economic	Non-Economic	Punitive	Unspecific
Indemnity insurer paid on behalf of defendant:	$0	$0	$0	$1,600
Other indemnity paid by/on behalf of defendant:	$0	$0	$0	$0
Indemnity paid by all parties (for all defendants):	$1,600			
Loss adjustment expense paid to defense counsel:	$4,000	**Misc. Comments:**		
All other allocated loss adjustment expenses paid:	$0			

Oregon Medical Board
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INDIVIDUAL MALPRACTICE REPORT

Malpractice claim information is compiled by the Oregon Medical Board from claim reports it receives from primary insurers; public bodies required to defend, save harmless and indemnify an officer, employee or agent of the public; self-insured entities; or health maintenance organizations. Claim reporting and disclosure requirements are governed by ORS 742.400.

LICENSEE / DEFENDANT

Licensee: Donald Clyde Willis MD
License #: MD10994
Birth Year: 1943
Specialty: Obstetrics and Gynecology
License Status: Expired
First Licensed: 01/13/78

Practice Address: Us Family Care 18182 Outer Hwy 18 Apple Valley, CA 92307
Practice Telephone #:

INSURER

Insurer: Kaiser Foundation Health Plan of the NW (SI) – NAIC #95540 -
Claim ID#:8619
Claim Reported to Insurer: 05/15/86
Claim Reported to Board: 07/13/88

CLAIM

Claim Allegation: PERFORATION OF ABDOMINAL AORTA DURING ELECTIVE TUBAL STERILIZATION. FAILURE TO ADVISE OF RISKS AND OTHER OPTIONS.

Injured Person's Gender: Female
Injured Person's Age: 39
Date of Injury: 05/19/85
Plaintiff (if not injured Person): None Reported
Total Defendants Involved in Claim: 1
Plaintiff Attorney: GREGORY A. SMITH - SALEM, OR
Institution Where Injury Occurred: BESS KAISER - PORTLAND, OR
InstitutionType / Location: (3) Hospital Outpatient Facility - (3) Operating Suite
Severity of Injury: (4) Temporary Major - Recovery Delayed
Issues Related to Diagnosis: (99) Not Applicable
Issues Related to Procedures: A - (99) Not applicable.
Others Contributing to Injury: B - (99) Not Applicable
Associated Claim Issues: C - (99) Not Applicable.
Policy Coverage: (3) Policy covers all claims whenever presented for events which occur during the policy term.
Companion Claim(s) ID Number:

SETTLEMENT

Claim Closed: 03/26/91
Claim Disposition: (3) Disposed of by binding arbitration.
Settlement Process: (99) Not Applicable.
Review Panel: (99) Not Applicable.
Court Decision: (0) No court proceedings were initiated.
Binding Arbitration: (2) Award for plaintiff.

	Economic	Non-Economic	Punitive	Unspecific
Indemnity insurer paid on behalf of defendant:	$0	$0	$0	$0
Other indemnity paid by/on behalf of defendant:	$0	$0	$0	$0
Indemnity paid by all parties (for all defendants):	$3,879,115			
Loss adjustment expense paid to defense counsel:	$289,139	**Misc. Comments:**		
All other allocated loss adjustment expenses paid:	$130,384			

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INDIVIDUAL MALPRACTICE REPORT

Malpractice claim information is compiled by the Oregon Medical Board from claim reports it receives from primary insurers; public bodies required to defend, save harmless and indemnify an officer, employee or agent of the public; self-insured entities; or health maintenance organizations. Claim reporting and disclosure requirements are governed by ORS 742.400.

LICENSEE / DEFENDANT

Licensee: Donald Clyde Willis MD
License #: MD10994
Birth Year: 1943
Specialty: Obstetrics and Gynecology
License Status: Expired
First Licensed: 01/13/78

Practice Address: Us Family Care 18182 Outer Hwy 18 Apple Valley, CA 92307
Practice Telephone #:

INSURER

Insurer: Kaiser Foundation Health Plan of the NW (SI) – NAIC #95540 -
Claim ID#:8729
Claim Reported to Insurer: 05/01/89
Claim Reported to Board: 07/08/91

CLAIM

Claim Allegation: FAILURE TO ADEQUATELY MONITOR A HIGH RISK PREGNANCY. FAILURE TO INFORM.

Injured Person's Gender: Female
Injured Person's Age: 27
Date of Injury: 06/30/87
Plaintiff (if not injured Person): None Reported
Total Defendants Involved in Claim: 7
Plaintiff Attorney: RICHARD ROGERS - PORTLAND, OR
Institution Where Injury Occurred: BESS KAISER - PORTLAND, OR
InstitutionType / Location: (1) Hospital Inpatient Facility - (2) Labor and Delivery Room
Severity of Injury: (9) Death
Issues Related to Diagnosis: (99) Not Applicable
Issues Related to Procedures: A - (03) There was a more appropriate alternative
Others Contributing to Injury: B - (01) Attending Physician
Associated Claim Issues: C - (15) Failure to provide warning instructions.
Policy Coverage: (3) Policy covers all claims whenever presented for events which occur during the policy term.
Companion Claim(s) ID Number:

SETTLEMENT

Claim Closed: 03/26/91
Claim Disposition: (3) Disposed of by binding arbitration.
Settlement Process: (99) Not Applicable.
Review Panel: (99) Not Applicable.
Court Decision: (0) No court proceedings were initiated.
Binding Arbitration: (2) Award for plaintiff.

	Economic	Non-Economic	Punitive	Unspecific
Indemnity insurer paid on behalf of defendant:	$0	$0	$0	$0
Other indemnity paid by/on behalf of defendant:	$0	$0	$0	$0
Indemnity paid by all parties (for all defendants):	$3,879,115			
Loss adjustment expense paid to defense counsel:	$289,139			
All other allocated loss adjustment expenses paid:	$130,384			

Misc. Comments:

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INDIVIDUAL MALPRACTICE REPORT

Malpractice claim information is compiled by the Oregon Medical Board from claim reports it receives from primary insurers; public bodies required to defend, save harmless and indemnify an officer, employee or agent of the public; self-insured entities; or health maintenance organizations. Claim reporting and disclosure requirements are governed by ORS 742.400.

LICENSEE / DEFENDANT

Licensee: Donald Clyde Willis MD
Specialty: Obstetrics and Gynecology
License #: MD10994
License Status: Expired
Birth Year: 1943
First Licensed: 01/13/78

Practice Address: Us Family Care 18182 Outer Hwy 18 Apple Valley, CA 92307
Practice Telephone #:

INSURER

Insurer: Kaiser Foundation Health Plan of the NW (SI) – NAIC #95540 -
Claim ID#:8562
Claim Reported to Insurer: 04/04/90
Claim Reported to Board: 04/18/90

CLAIM

Claim Allegation: FAILURE TO PERFORM C-SECTION, FAILURE TO DIAGNOSE DEVELOPMENTAL DELAY.

Injured Person's Gender: Male
Injured Person's Age:
Date of Injury: 03/19/86
Plaintiff (if not injured Person): (3) Parent
Total Defendants Involved in Claim: 5
Plaintiff Attorney: KEVIN CHAMES - PORTLAND, OR
Institution Where Injury Occurred: BESS KAISER - PORTLAND, OR
InstitutionType / Location: (1) Hospital Inpatient Facility - (2) Labor and Delivery Room
Severity of Injury: (8) Permanent Grave
Issues Related to Diagnosis: (1) Delay in diagnosis
Issues Related to Procedures: A - (04) Delayed
Others Contributing to Injury: B - (99) Not Applicable
Associated Claim Issues: C - (99) Not Applicable.
Policy Coverage: (3) Policy covers all claims whenever presented for events which occur during the policy term.
Companion Claim(s) ID Number:

SETTLEMENT

Claim Closed: 05/30/91
Claim Disposition: (1) Settled by parties
Settlement Process: (2) Before trial or hearing.
Review Panel: (99) Not Applicable.
Court Decision: (9) All others
Binding Arbitration: N/A

	Economic	Non-Economic	Punitive	Unspecific
Indemnity insurer paid on behalf of defendant:	$0	$0	$0	$0
Other indemnity paid by/on behalf of defendant:	$0	$0	$0	$0
Indemnity paid by all parties (for all defendants):	$1,425,000			
Loss adjustment expense paid to defense counsel:	$89,097			
All other allocated loss adjustment expenses paid:	$43,274			

Misc. Comments:

DATE REQUESTED

MAR 15 1977

OCT 25 1977

DO NOT DETACH OR MUTILATE THIS FORM

STATE OF OREGON

BOARD OF MEDICAL EXAMINERS

1002 LOYALTY BUILDING PORTLAND, OREGON 97204

APPLICATION FOR LICENSURE TO PRACTICE MEDICINE BASED UPON RECIPROCITY OR ENDORSEMENT OR BY OREGON STATE BOARD WRITTEN EXAMINATION

FOR USE OF MEDICAL EXAMINERS

COMPLETE	INTERVIEWED BY:	DATE FILED	LICENSE NO.
	PASS ☒	SEP 28 1977	10994
	FAIL ☐	FEE PAID PB 100	DATE LICENSE ISSUED 1/13/78

INSTRUCTIONS

1. This application, together with the fee and documents required by the rules, must be filed with the Executive Secretary, Board of Medical Examiners, State of Oregon, at l 45 days prior to the date of interview.
2. If this application is withdrawn or rejected, 50% will be refunded.
3. Read this application carefully and answer all questions. If answer is "no" or "none" so state. If additional space is needed for answer, attach separate sheet.
4. All documents supporting this application must be 8½" x 11".
5. Complete on typewriter or in ink.

I hereby apply for a license to practice medicine in the State of Oregon and submit the following proofs of my qualifications as required by the Board of Medical Examin State of Oregon.

PERSONAL DATA

FIRST NAME	MIDDLE NAME	LAST NAME
Donald	Clyde	WILLIS

PROFESSIONAL ADDRESS: Dept. of Gyn & Ob, Stanford Univ.Medical Center Stanford, CA 94305 — ZIP CODE

BUSINESS TELEPHONE: 497-5505 (Area Cod 415)

RESIDENCE ADDRESS — ZIP CODE

HOME TELEPHONE (Area Cod)

PLACE OF BIRTH (City and State)

DATE OF BIRTH (Month, Day, Year): 1943

FEDERAL NARCOTIC NUMBER:

SCHOOL HISTORY

HIGH SCHOOL (Name and Location of High School Attended): Milwaukie High School, Milwaukie, Oregon — YEAR GRADUAT 1961

PREMEDICAL OR PREOSTEOPATHIC EDUCATION (Name and Location of College or University Attended): Northwest Nazarene College, Nampa, Idaho from 9-61 to 6-65 A.B. June 9,196

ATTENDED FROM (Month, Day, Year)	TO (Month, Day, Year)	DEGREE RECEIVED	DATE OF DEGREE (Month, Day, Y
University of Portland, Portland, Oregon from 9-66	to 10-70	Ph.D.	Oct.4,197

MEDICAL OR OSTEOPATHIC SCHOOL HISTORY

LEGAL NAME AND LOCATION OF MEDICAL OR OSTEOPATHIC SCHOOL	FROM (Month, Day, Year)	TO (Month, Day, Year)
1. Indiana University School of Medicine Indianapolis, Indiana	8-22-72	2-29-76
2.		
3.		
4.		
5.		

I WAS GRANTED A DEGREE AS DOCTOR OF MEDICINE OR DOCTOR OF OSTEOPATHY BY: LEGAL NAME AND LOCATION OF MEDICAL SCHOOL OR OSTEOPATHIC SCHOOL: Indiana University School of Medicine, Indianapolis, In. — DATE OF DEGREE (Month, Day, Y Feb. 29, 1976

FOLLOWING WRITTEN EXAMINATION, I WAS GRANTED A LICENSE OR CERTIFICATE BY: NAME OF STATE MEDICAL BOARD OR NATIONAL BOARD OF MEDICAL OR OSTEOPAT EXAMINERS UPON WHICH THIS APPLICATION IS BASED: None National Board

LICENSES AND CERTIFICATES

LICENSE OR CERTIFICATE NO.: None

DATE OF LICENSE OR CERTIFICATE (Month, Day, Year):

I RECEIVED ON THIS EXAMINATION A GENERAL AVERAGE OF

I HAVE APPLIED FOR A LICENSE TO THE FOLLOWING STATES OR COUNTRIES:	YEAR	RESULT Granted	RESULT Denied	LICENSE IS CURRENT Yes	LICENSE IS CURRENT No	APPLICATION TO THAT STATE OR COUNTRY BASED UPON
1. California	19 77	?	?			☒ ENDORSEMENT ☐ RECIPROCITY ☐ WRITT
2.	19					☐ ENDORSEMENT ☐ RECIPROCITY ☐ WRITT
3.	19					☐ ENDORSEMENT ☐ RECIPROCITY ☐ WRITT
4.	19					☐ ENDORSEMENT ☐ RECIPROCITY ☐ WRITT
5.	19					☐ ENDORSEMENT ☐ RECIPROCITY ☐ WRITT
6.	19					☐ ENDORSEMENT ☐ RECIPROCITY ☐ WRITT

LIST BELOW IN CHRONOLOGICAL ORDER All Periods of Time AFTER MEDICAL or OSTEOPATHIC SCHOOL to the PRESENT TI

If additional space is needed, attach addendum. A Curriculum Vitae is NOT acceptable in lieu of completion of this form.

TYPE OF PRACTICE

TYPE OF PRACTICE— internship, residency, fellowship, practice, etc.	NAME OF INSTITUTION OR PLACE OF PRACTICE AND LOCATION	FROM (Month, Day, Year)	TO (Month, Day, Year)
Internship	Royal Jubilee Hospital Victoria, B.C., Canada	6-15-76	6-14-77
Residency	Dept. of GYN & OB Stanford Univ.Med.Cntr., Stanford, CA 94305	7-1-77	Present

SPECIALTY PREFERRED	SPECIALTY BOARD	DATE CERTIFIED (Month, Day, Year)
Obstetrics & Gynecology		

MILITARY SERVICE

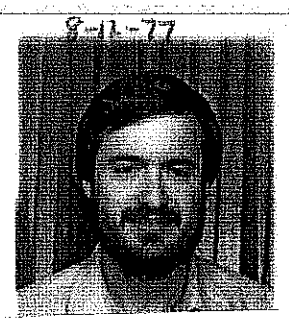
BRANCH (Active Duty)	FROM (Month, Day, Year)	TO (Month, Day, Year)	RANK AT SEPARATION
None			

ARE YOU NOW REGISTERED FOR MILITARY SERVICE? YES ☐ NO ☒	IF YES, WHAT IS YOUR PRESENT STATUS?	IF NO, GIVE REASON

PASTE PHOTOGRAPH HERE

MUST BE NO LARGER THAN 3" x 4", TAKEN WITHIN ONE YEAR OF APPLICATION

ENTER DATE TAKEN ON PHOTOGRAPH AND SIGN IN INK ACROSS BOTTOM



PERSONAL HISTORY

IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED "YES", FULL DETAILS MUST BE FURNISHED ON SEPARATE SHEET AND ATTACHED.

1. DO YOU HOLD A LICENSE IN ANY OF THE OTHER HEALING ARTS? . . . 1.
2. HAVE YOU EVER BEEN CALLED BEFORE ANY STATE BOARD OR ANY MEDICAL OR OSTEOPATHIC ASSOCIATION FOR INTERROGATION CONCERNING ANY VIOLATION OF THE MEDICAL OR OSTEOPATHIC PRACTICE ACT OR UNETHICAL CONDUCT? . 2.
3. HAVE YOU EVER BEEN CONVICTED OF A FELONY OR MISDEMEANOR OTHER THAN MINOR TRAFFIC VIOLATIONS? . . . . . 3.
4. HAVE YOU EVER [redacted] TREATED FOR ADDICTION TO DRUGS? 4.
5. HAVE YOU EVER MADE AN OFFER TO COMPROMISE IN CONNECTION WITH THE CONTROLLED SUBSTANCES ACT OF 1970, OR ANY OTHER NARCOTIC OR DRUG CONTROL LAW? . . . . . 5.
6. HAVE YOU EVER RECEIVED PSYCHIATRIC TREATMENT OR RECEIVED TREATMENT FOR A MENTAL ILLNESS? . . . . . 6.
7. HAVE YOU EVER ENGAGED IN THE EXCESSIVE OR HABITUAL USE OF ALCOHOL OR RECEIVED TREATMENT FOR ALCOHOLISM? . . . . . 7.
8. HAVE YOU EVER ENGAGED IN THE PRACTICE OF MEDICINE IN A STATE, DISTRICT OR TERRITORY WHEREIN YOU DID NOT HOLD A VALID LICENSE? . . . . 8.
9. HAVE YOU EVER HAD AN APPLICATION FOR LICENSURE REFUSED OR REJECTED BY A LICENSING BOARD? . . . . . .

IDENTIFICATION

HEIGHT (Ft. & In.)	WEIGHT	HAIR	EYES	OF HERE

COMPLEXION	SCARS AND MARKS

AFFIDAVIT OF APPLICANT

I, Donald Clyde Willis, being first duly sworn, depose and say that I am the person above described and identified; that I have not engage
(Applicant to Print or Type His FULL Name)
in any of the acts prohibited by the statutes of the State of Oregon, particularly those acts [illegible] in sections ORS 677.080 or ORS 677.190.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates, busines associations (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files o records requested by this Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and group listed above any information which is material to my application or pertinent to my practice of medicine during the time that I am a licentiate of this Board.

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and I declare under penalty o perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that suc act shall constitute cause for the denial, suspension or revocation of my license to practice medicine in the State of Oregon.

Subscribed and sworn to before me this 19th day of September, 197

Helen H Rantz

(APPLICANT TO SIGN HIS USUAL BUSINESS SIGNATURE)

(SEAL)

Notary Public for State of California, Santa Clara Co

My commission expires Aug. 14, 1979

HELEN H. RANTZ, NOTARY PUBLIC

THIS PAGE TO BE COMPLETED ONLY BY THE DEAN'S OFFICE OF THE MEDICAL OR OSTEOPATHIC SCHOOL

A person selected by the dean of the medical or osteopathic school will place the exact dates of attendance of the applicant at the school or college, showing the begi and ending dates along with the official seal of the school. The certification must show the required dates and seal or application will not be accepted.

CERTIFICATION BY MEDICAL OR OSTEOPATHIC SCHOOL

FULL NAME OF APPLICANT

Donald Clyde Willis, M.D.

DATE OF DEGREE

February 29, 1976

DATES OF ATTENDANCE

	FROM (Month, Day, Year)	TO (Month, Day, Year)
1st year	August 1972	May 1973
2nd year	August 1973	May 1974
3rd year	May 1974	May 1975
4th year	June 1975	February 1976

THE FOLLOWING PORTION MAY BE USED BY THE **DEAN** TO FURNISH HIS COMMENTS REGARDING THE ABOVE APPLICANT'S MORAL AND ETHICAL CHARACT WHILE A STUDENT AT THE SCHOOL. — **OR** — THE **DEAN** MAY FORWARD A LETTER DIRECTLY TO THE BOARD SHOWING SATISFACTORY EVIDENCE OF GOOD MOR AND ETHICAL CHARACTER.

SIGNATURE OF DEAN

LEGAL NAME OF MEDICAL OR OSTEOPATHIC SCHOOL AT THE TIME OF GRADUATION

Indiana University School of Medicine

PRESENT LEGAL NAME OF MEDICAL OR OSTEOPATHIC SCHOOL IF THE NAME HAS BEEN CHANGED

(SEAL)

CITY

Indianapolis

STATE

Indiana

DATE OF THIS CERTIFICATION

October 20, 1977

THIS PAGE TO BE COMPLETED **ONLY** BY THE STATE BOARD OR NATIONAL BOARD UPON WHICH THIS APPLICATION IS BASED.
NOTE TO THE BOARD: IF THE LICENSE HAS **NOT** BEEN OBTAINED BY WRITTEN EXAMINATION, **DO NOT** CERTIFY THIS PAGE.

NOTE: This endorsement shall not be executed unless applicant has completed pages 1 and 2 of this application, executed the affidavit on page 2, and affixe his photograph on page 2.

CERTIFICATION OF SECRETARY OF BOARD ISSUING LICENSE OR CERTIFICATE

NAME OF APPLICANT	ADDRESS OF APPLICANT
Endorsement of Certification is enroute from NBME (Candidate # 171287)	
GRADUATED FROM (LEGAL NAME OF MEDICAL OR OSTEOPATHIC SCHOOL)	DATE OF GRADUATION (Month, Day, Year)
STATE LICENSE OR CERTIFICATE NO.	DATE LICENSE OR CERTIFICATE ISSUED
DATE OF WRITTEN EXAMINATION	THE APPLICANT OBTAINED ON THIS WRITTEN EXAMINATION A GENERAL AVERAGE OF %

NOTE: ALL GRADES ARE TO BE PLACED DIRECTLY ON THIS FORM

SUBJECT	SCORE	SUBJECT	SCORE
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

IF BY FLEX EXAMINATION, COMPLETE THE FOLLOWING ALSO

Basic Science Average			
Clinical Science Average			
Clinical Competence Average			
Flex Weighted Average			

As secretary of the board, I certify that the state license or certificate shown above was issued to the applicant named on the date shown, based upon the qualifications stat above.

1. I FURTHER CERTIFY THAT THE PHOTOGRAPH AFFIXED TO PAGE 2 OF THIS APPLICATION IS A TRUE LIKENESS OF THE APPLICANT. (Statements 1 and 3 do not apply National Board.)
2. I further certify that the license or certificate named above has not been revoked or suspended.
3. I further certify that, from the records now on file in this office, I believe the applicant to be of good moral character and worthy of professional recognition. I recommer the applicant as a fit and proper person to receive recognition as an applicant for a license by the Board of Medical Examiners, State of Oregon, under the medical lav of Oregon.

In testimony whereof, witness my hand and seal of said board.

(SEAL)

SIGNATURE

NAME OF BOARD

ADDRESS

DATE OF THIS CERTIFICATION

SP*7403-3

INDIANA UNIVERSITY

School of Medicine

To all to whom these Presents may come, Greeting:

By vote of the Faculty and with the consent of the Board of Trustees, Indiana University hereby confers upon

Donald Clyde Willis

who has complied with all the requirements of the University and has successfully completed the studies prescribed for graduation in the School of Medicine the degree of

Doctor of Medicine,

with all the rights and privileges thereunto appertaining.

In Testimony Whereof, this Diploma is issued, sealed with the Seal of the University, signed by the President of the University, Vice President, and by the Dean of the School of Medicine, and attested by the Secretary of the Trustees.

Done at Indiana University - Purdue University at Indianapolis, Indiana, this twenty-ninth day of February 1976.

Dean of the School of Medicine

President

Secretary of the Trustees

Vice President

Royal Jubilee Hospital

Victoria, B.C.

Diploma

This is to Certify that

D. C. Willis, M.D.

has satisfactorily completed a
Junior Rotating Internship
from June 15, 1976 to June 14, 1977
in this hospital

In Witness Whereof the undersigned have affixed their signatures

this 14th day of June 1977.

PRESIDENT BOARD OF DIRECTORS

PROGRAM DIRECTOR

EXECUTIVE DIRECTOR

MEDICAL DIRECTOR

VICTOR ATIYEH
GOVERNOR

Department of Human Resources
HEALTH DIVISION
Board of Medical Examiners
1002 LOYALTY BLDG., 317 S.W. ALDER ST., PORTLAND, OREGON 97204 PH. (503) 229-5770

September 8, 1980

Donald C. Willis, M. D.
5317 N. E. 34th Avenue
Portland, Oregon 97211

Dear Doctor:

This is to advise that the Board has processed the affidavit of your activities, and your request for reactivation of your Oregon license has been approved.

I am enclosing an application for registration to be completed and returned to this office with your check in the amount of $20.00. On the application form show your OREGON business address and the effective date you plan to begin Oregon practice. Your application and fee must be received by this office prior to beginning your Oregon practice.

If your Oregon location plans are indefinite, and you do not expect to move to oregon within the next two months, do not submit your application and check at this time; rather, delay payment until just prior to your move to Oregon.

I am also enclosing a copy of the Oregon Medical Practice Act, General Information Bulletin and Doctor's Title Law. Review this information prior to beginning your Oregon practice.

If you have any questions concerning this letter, do not hesitate to contact me.

Very truly yours,

JOHN J. ULWELLING
Executive Secretary

Ms. Jan Baggenstos
License Administrator
JJU:JB:dlm
Enclosures

DATE SENT [illegible]

BOARD OF MEDICAL EXAMINERS, STATE OF OREGON
317 S. W. ALDER ST., 1002 LOYALTY BLDG.
PORTLAND, OREGON 97204 (503) 229-5770

DATE RECD JUL 17 1980

AFFIDAVIT FOR REACTIVATION OF OREGON LICENSE

IMPORTANT: ANSWER ALL QUESTIONS. If not applicable, put N/A. If answer is yes, give full details where indicated. If necessary, attach a separate sheet of paper.

The Oregon State Board of Medical Examiners reserves the right to investigate the answers to all the following questions. Inactive license # 10994

First name	Middle name	Last name
DONALD	CLYDE	WILLIS

Mailing address		zip code	Phone (area code)
5317 N.E. 34th Ave	Portland, OR	97211	(503) 288-4740

Medical/Osteopathic School & Location & Date Graduated	Federal Narcotic Number
Indiana University Medical School Indianapolis 2-29-76	

Practice locations since leaving Oregon/since Oregon licensure

TYPE OF ACTIVITY residency, practice, etc.	NAME OF HOSPITAL OR PLACE OF PRACTICE AND LOCATION	FROM (mo, day, yr)	TO (mo, day, yr)
Residency	Stanford University	7-1-77	6-30-80
	Dept. OB/GYN		
	Stanford, CA 94305		

Branch of Military Service	From (mo, day, yr)	To (mo, day, yr)
None		

Specialty Preferred	Specialty Board	Date certified
OB GYN		

Name the states where you have applied for licensure

State	Date	Granted	Denied	If denied, give reason.
1. California	1977	X		
2. Oregon	1-13-78	X 10994		
3.				

How long since you have been a resident in Oregon? 8 yrs. Give last location of practice in Oregon None
How many years? _____ Reason for leaving To do residency as above.

If you have not continued your inactive annual registration and thus have permitted your entire registration in Oregon to lapse, state reasons: _____

(see reverse)

IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED "YES", FULL DETAILS MUST BE FURNISHED ON A SEPARATE SHEET AND ATTACHED.

YES NO

1. Have you ceased the active practice of medicine/osteopathy? Why?

2. Have you ever been denied Staff Membership in any hospital?

3. Have you ever been accused of malpractice? Was a settlement made?

4. Do you hold a license in any other healing art?

5. Have you ever been called before any state board for interrogation concerning any violation of the Medical/Osteopathic Practice Act for unethical conduct?

6. Have you ever been convicted of a felony or misdemeanor other than traffic violations?

7. Have you ever used drugs or been treated for addiction to any drugs?

8. Have you ever made an offer to compromise in connection with the Controlled Substances Act of 1970, or any other narcotic or drug control law?

9. Have you ever received psychiatric treatment or received treatment for a mental illness?

10. Have you ever engaged in the excessive use of alcohol or received treatment for alcoholism?
Are you a member of "Alcoholics Anonymous"? ____ Have you ever been? ____

11. Have you ever been denied membership in a County, District or State Medical/Osteopathic Society?

12. Have you ever been called before a Board of Censors of any County, District or State Medical/Osteopathic Society?

Attach a recent 3"x4" photograph signed and dated. (Snapshots are acceptable)

Identification

Height	Weight	Hair	Eyes

Complexion	Scars & Marks

Birthplace (city, state)	Birthdate
	43

(Signature of Applicant)

Subscribed and sworn to before me, this 15th day of July, 19 80.

Patricia A. Miles
(Notary Public for)

My commission expires 10-2-83, 19____.

(SEAL)

BOARD OF MEDICAL EXAMINERS, STATE OF OREGON
317 S. W. ALDER ST. 1002 LOYALTY BLDG.
PORTLAND, OREGON 97204 (503) 229-5770

FIRST DONALD	MIDDLE CLYDE	LAST WILLIS

Please list below the hospitals in which you have or have had staff privileges while in military service and/or practice (not training)

Name and mailing address of the hospitals (Include zip code)	Person to Contact	Membership Dates From	To	Status ACTIVE COURTESY
Training only				

I have never had staff privileges in any hospital check here [X]

List below all County Medical or Osteopathic Societies of which you are or have been a member. (The applicant must request a letter from each society of which he has been a member verifying membership and standing with the society.

Name and mailing address of societies	Dates of Membership From	To
None		

I have never been a member of a county medical or osteopathic society. check here [X]

As this form is an addendum to the Application for Licensure, your signed authorization for Release of Information on page 2 of the application will apply to this addendum as well.

Date signed
X 7-14-80
Applicant's Business Signature

ADDENDUM TO APPLICATION FOR LICENSURE

VICTOR ATIYEH
GOVERNOR

Department of Human Resources
HEALTH DIVISION
Board of Medical Examiners
1002 LOYALTY BLDG., 317 S.W. ALDER ST., PORTLAND, OREGON 97204 PH. (503) 229-5770

AUTHORIZATION FOR RELEASE

I, DONALD C. WILLIS, being first
(Applicant to Print or Type His FULL Name)

duly sworn, depose and say that I have not engaged in any of the acts prohibited by the statutes of the State of Oregon, particularly those acts set forth in Sections ORS 677.080 or ORS 677.190.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates, business associations (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files or records requested by this Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practice of medicine during the time that I am a licentiate of this Board.

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine in the State of Oregon.

Subscribed and sworn
to before me this 15th day of July, 19 80

X _____
(Applicant to sign his usual business signature)

X Patricia A. Miller
(Notary Public signature)

Notary Public for State of Oregon

My commission expires 10-2-83, 19____

(SEAL)

OREGON BOARD OF MEDICAL EXAMINERS
620 Crown Plaza, 1500 SW 1st Ave
Portland, OR 97201-5826
503 / 229-5873 ext 233 (Registration Inquiries)

APPLICATION FOR REGISTRATION

1999

Payment is due by Dec. 1st
Suspended on January 1st

IMPORTANT: Please read instruction sheet before completing application and questionnaire. All numbered items must be verified or completed and form signed on reverse side or it will be returned for completion, which will **DELAY** registration. Mailing address is available to the public.

1. B MD10994
WILLIS, DONALD CLYDE; MD
US FAMILY CARE
18182 OUTER HWY 18
APPLE VALLEY, CA 92307

The mailing address on left (change if necessary) is:
- ☐ Business
- ☐ Residence
- ☐ Other _____ (billing, parents, etc.)

Current Status: INACTIVE Type: MD Date Licensed: 01/13/1978

2. **NONREFUNDABLE FEES:** Make check payable to 'Board of Medical Examiners' (U.S. funds, drawn on a U.S. bank only). **(Important: SEE INSTRUCTIONS)**

$330.00 (2 years)	☐	ACTIVE (Practicing in Oregon; or in Military or Public health and Oregon is your official address)
$270.00 (2 years)	☐	INACTIVE (Not practicing in Oregon)
$330.00 (2 years)	☐	LOCUM TENENS (See instructions and complete item #15 below)
$165.00 (1 year)	☐	ACTIVE (Physicians in post medical school training only) **Requires written signed statement.**
$ 85.00 (1 year)	☐	EMERITUS (Retired, volunteer nonremunerative practice) **Requires written signed statement.**
NO FEE	☐	RETIRED (Not practicing any form of medicine) **Requires written signed statement.**

3. Business Street Address

4. Residence Street Address

5. Date of birth : 1943
6. Business telephone # :
7. Residence telephone # :
8. Oregon Business County : NONE/UNKNOWN
9. Social Security # :
10. Specialty :
11. Amer. Board Certified for above Spec. : yes

12. Will you purchase drugs to give or sell to your **Oregon** patients during the current registration period? ☐ Yes ☐ No
(IMPORTANT - See instructions for definition of dispensing physician).

13. If you have retired or moved your practice, list address and telephone # for former **Oregon** patients' records:
KAISER PERM, 500 NE MULTNOMAN ST #100, PORTLAND, OR 97232 813-3892

14. If retired, do you: ☐ Volunteer ☐ Consult ☐ Practice Part-Time ☐ Not Practice

15. Physicians who wish Locum Tenens status - list conditions, dates, place and contact name of proposed Oregon practice **OR** list name, address, and telephone number of Locum Tenens agency.

16. List all Oregon Staff privileges (hospital name and location) Active or Locum Tenens physicians only:

17. List states where you are currently licensed.

2YR APPL

QUESTIONNAIRE

Answer all questions on pages 2 and 3 below. Category I will help the Board determine if you meet the essential eligibility requirements for registration renewal by virtue of your background, education, training and experience. If you are qualified to practice under Category I, Category II will be reviewed to help the Board determine if you are qualified to practice safely and competently, with or without reasonable modification.

If you answer "yes" to any of the questions, you must use page 4 or attach a complete written explanation of the event(s) or condition(s), including dates, names, addresses, circumstances, and results along with your returned application.

NOTE: Fraud or misrepresentation in applying for or procuring a license, registration or reactivation in Oregon are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organizations.

Category I

SINCE THE LAST REGISTRATION PERIOD

YES	NO	
☐	☐	1. Do you hold any licenses to practice another health care profession?
☐	☐	2. Have you failed a state or national examination to qualify for a state license to practice a health care profession?
☐	☐	3. Have you engaged in the unlicensed practice of any health care profession when you were required by law to have a license?
☐	☐	4. Has any state licensing board refused to issue, refused to renew, or denied you a license to practice?
☐	☐	5. Have you been asked to make a written or verbal response to an investigation or inquiry by a licensing board?
☐	☐	6. Has any licensing board taken any disciplinary action against you, or revoked, suspended, placed on probation, limited or restricted your license?
☐	☐	7. Have you been denied approval to prescribe controlled substances, or been charged with a violation of federal or state narcotic laws, or been asked to surrender your DEA number?
☐	☐	8. Have you been convicted of a felony or misdemeanor?
☐	☐	9. To your knowledge, are you currently the subject of any criminal or civil investigation?
☐	☐	10. Have any charges of malpractice been brought against you?
☐	☐	11. Have you interrupted the practice of your health care profession for one year or more, or ceased the practice of your specialty?
☐	☐	12. Have you been restricted, suspended, terminated, requested to voluntarily resign, placed on probation or been subject to formal disciplinary action during a medically related training program?
☐	☐	13. Have you had hospital privileges denied, reduced, restricted, suspended, or been placed on probation, revoked, requested to voluntarily resign, or been subject to staff disciplinary action?
☐	☐	14. Have you ceased the active practice of medicine in your specialty?
☐	☐	15. Have you changed your practice specialty? (Have you corrected item #10 on Page 1?)

The answers to these questions are exempt from public disclosure under ORS 192.505(2), the Oregon Public Records Law, unless a party seeking disclosure, by clear and convincing evidence, shows that disclosure would not be an unreasonable invasion of privacy and that the public interest requires disclosure in the particular instance. The answers to these questions may be considered by the Board and may be disclosed in any contested case hearing or appeal of a licensing decision based upon them.

If applicable, these questions should be read to include the clause, "Other than what is known already to the Oregon Diversion Program for Health Professionals, . . ."

"Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the directions of the licensed health care professional who prescribed the controlled substance or dangerous drug.

Category II
SINCE THE LAST REGISTRATION PERIOD

YES	NO	
☐	☐	1. Do you currently, or have you had any physical, mental, or emotional condition which impaired, or does impair your ability to practice your health care profession safely and competently?
☐	☐	2. Have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition?
☐	☐	3. Do you currently have, or have you had a dependency on the use of alcohol or drugs which impaired, or does impair, your ability to practice your health care profession safely and competently?
☐	☐	4. Have you engaged in the excessive or habitual use of alcohol or illegal drugs, or received any in-patient therapy/treatment or been hospitalized for alcoholism, or illegal drug use, or been arrested for a DUII (Driving Under the Influence of Intoxicants) or DWI (Driving While Intoxicated)?
☐	☐	5. Have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .08% BAC (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional)?

I certify that the information submitted by me is true, accurate, and complete to the best of my knowledge. I understand that failure to answer the questions fully and correctly, may be grounds for disciplinary action by the Board, ORS 677.205.

Physician's Signature _____ Date 12-15-97
(signature stamps or proxy NOT acceptable)

CHECKLIST Did You:

- Read the instructions?
- Verify/complete all items on Page 1?
- Answer all questions above & enclose written explanations for all "Yes" answers?
- Sign and date form?
- Enclose proper fee? Is the date correct? Are amounts, both written & numerical the same?
- Is the check signed?
- Enclose original registration/questionnaire form? (Photocopies NOT acceptable)

Use this form to make the required written explanation concerning any affirmative responses to the questionnaire and any other requested statements. Make additional copies of this form if necessary. Include dates, names, addresses, circumstances, and results.