RECEIVED
Date Received by Board
HAND-DELIVERED
JUN 25 2015
NEVADA STATE BOARD OF MEDICAL EXAMINERS

License No. 1565 1
File No.
ACTIVE

PHYSICIAN
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2015 – 2017
NEVADA STATE BOARD OF MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below:

☒ ACTIVE STATUS ---------- $780.00
☐ INACTIVE STATUS ---------- $405.00
SAVE $20 by renewing online at www.medboard.nv.gov

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. Funds")
Credit card authorization may also be utilized.

6/26/15

PLEASE NOTE THE FOLLOWING IMPORTANT INSTRUCTIONS REGARDING YOUR APPLICATION:

- Your current physician's license expires on **JUNE 30, 2015**. If this form is not received by the Nevada State Board of Medical Examiners' (Board) office by July 1, 2015 at 5:00 p.m., your license will be automatically expired and you will not be able to practice medicine until you reinstate your license. **NEVADA HAS NO GRACE PERIOD**.
- Your license will not be renewed unless you answer **ALL** questions on this application and provide written explanation(s) for any/all question(s) answered "yes".
- Your license will not be renewed until the board receives your original signed *Application for Registration Renewal* form. **A faxed copy is not acceptable.**
- Your license will not be renewed unless it is accompanied with a check for the proper fee or credit card authorization.
- You may have been selected in a random continuing medical education (CME) audit of all licensees. If you were randomly selected, you will be contacted by the Board for proof of your CME. Your license will not be renewed if you do not have proof of the required CME. Refer to page 5 for a review of your CME requirement. Please retain proof of your CME as the Board does not retain copies.
- All information provided on this application is **PUBLIC** information.
- If you select "INACTIVE STATUS," you are prohibited from practicing medicine and prohibited from writing prescriptions in the state of Nevada. Inactive licensees are not required to submit proof of CME.
- **PLEASE TYPE OR PRINT LEGIBLY.**

RENEWED
7/1/15 - 6/30/17
BIENNIAL

Please print your name and address clearly in the space provided below. Be advised that the address you provide below is viewable on the Board website and is listed as the public address. Also, please provide your current public telephone and fax numbers. [Note: If your name has changed, a copy of the document authorizing your legal name change (marriage license, divorce decree, etc.) must be included.]

Name DONALD CLYDE WILLIS
Street 5915 TYRONE Rd
City RENO County WASHOE State NV
Zip 89502
Phone Number 775. 829. 0616
Cell Phone Number
Fax Number
E-mail address

Please indicate any American Board of Medical Specialties Board Certification or Recertification:

	Date of Initial Certification (Mo./Yr.)	Date of Last Recertification (Mo./Yr.)
Board:	Am. Board OB&GYN 11-1982	
Subboard:		

If any of the ABMS Certifications or Recertifications were received after your last application with the Board, please attach copies of documents evidencing your Certifications or Recertifications.

QUESTIONS

For the purposes of the following questions, these phrases or words have these meanings:

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

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

"Medical condition" includes physiological, mental or psychological condition or disorder.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

Please answer all of the following questions for the time period **July 1, 2013 – June 30, 2015, or since your last renewal**.

For all YES responses to the following questions, you must submit your written explanation(s) on a separate sheet attached to this form.

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ____Yes __X__No
2. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice, or by any other reasonable accommodation? ____Yes ____No __X__N/A
3. If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? ____Yes ____No __X__N/A
4. Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? ____Yes __X__No
5. Have you had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? ____Yes __X__No
6. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you **MUST disclose ANY** investigation or arrest, including those where the final disposition was dismissal, or expungement. ____Yes __X__No
7. Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? ____Yes __X__No

8. Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? ____Yes X No

9. Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action? ____Yes X No

10. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ____Yes X No

11. Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? ____Yes X No

12. Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? ____Yes X No

13. Have you had staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? ***If the answer is "YES," on a separate sheet list the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken.*** (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.) ____Yes X No

14. Have you actively practiced medicine in Nevada within the past 12 months? X Yes ____No

If your answer is "yes", please indicate the approximate percentage of time allotted to the following medical activities.

Clinical practice 100 % Administrative ____% Teaching ____% Other ____%

ATTESTATIONS / AFFIRMATION

CHILD SUPPORT STATEMENT

PLEASE PLACE AN "X" NEXT TO THE STATEMENT THAT APPLIES TO YOU:

X I am not subject to a court order for the support of a child;

____ I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

____ I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child. X Yes ____No

SAFE INJECTION PRACTICE ATTESTATION

ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT PHYSICIANS

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to Chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.

X Yes _____ No

MILITARY SERVICE ATTESTATION

Have you ever served in the United States Military (to include National Guard or Reserves)? X Yes _____ No

If your answer is "No", you do not have to complete the remaining questions for the Military Service Attestation.

If yes, in which branch of service did you serve?

- ☐ Air Force
- ☐ Army
- ☒ Navy
- ☐ Marine Corp
- ☐ Coast Guard

Military occupation specialty or specialties?

- ☐ Administration or Personnel
- ☐ Aviation
- ☐ Civil Engineering
- ☐ Communications
- ☐ Infantry or Armor
- ☐ Legal or Chanlin Corps
- ☐ Logistics or Supply
- ☐ Maintenance
- ☒ Medical Services
- ☐ Security Forces or Military Police
- ☐ Other

Dates of service in the Military:

From: ____/____/____ (DD/MM/YYYY) To: 07/____/____ (DD/MM/YYYY)

BUSINESS LICENSE ATTESTATION

Do you hold a Nevada state business license issued in your individual name? _____ Yes X No

If yes, provide the business license number: _____.

CONSCIOUS SEDATION DEEP SEDATION OR GENERAL ANESTHESIA ATTESTATION

Nevada Revised Statutes (NRS) require the Nevada State Board of Medical Examiners to obtain from each applicant who seeks renewal of his or her license to practice medicine, a report stating the number and type of surgeries requiring conscious sedation, deep sedation or general anesthesia performed by the holder of the license at his or her office or any other facility, excluding any surgical care performed at a medical facility as defined in NRS 449.0151, or outside the state of Nevada.

I hereby attest that I am in compliance with the reporting requirements of NRS 630.30665. I am aware that failure to submit a report or filing false information in a report is grounds for disciplinary action under Nevada's Medical Practice Act.

****** I HAVE SUBMITTED MY A OR B REPORT TO THE BOARD:*** X Yes _____ No

COMMUNICATIONS AFFIRMATION

Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for physicians and physician assistants who practice medicine in the state of Nevada or telemedicine and whose physical presence exists outside the state of Nevada or the United States

I hereby agree that as a condition of obtaining or maintaining licensure with the Board, I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change, and that the failure to do so may subject me to a fine or disciplinary action as allowed in NRS 630.244.

Printed Name of Applicant/Licensee: DONALD CLYDE WILLIS

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____

CONTINUING EDUCATION

ATTENTION LICENSEE: YOU MAY HAVE BEEN SELECTED IN THE CONTINUING MEDICAL EDUCATION (CME) AUDIT. IF YOU WERE SELECTED, YOUR RENEWAL WILL NOT BE PROCESSED UNTIL PROOF OF YOUR CME HAS BEEN SUBMITTED AND APPROVED. YOU WILL BE NOTIFIED BY THE BOARD ONCE YOUR PAPER RENEWAL APPLICATION HAS BEEN SUBMITTED WHETHER YOU ARE INCLUDED IN THE AUDIT.

ALL CONTINUING MEDICAL EDUCATION MUST HAVE BEEN COMPLETED DURING THE PERIOD OF JULY 1, 2013 THROUGH JUNE 30, 2015. Please place a check mark next to the statement that applies to you.

_____ I was initially licensed in Nevada prior to July 1, 2013 or during the first 6 months of the biennial period of registration (July 1, 2013 through December 31, 2013) and have completed a minimum of forty (40) hours of AMA Category 1 continuing medical education (CME), two (2) hours of which were in medical ethics or pain management and/or addiction care and twenty (20) hours of which were in my scope of practice or specialty.

_____ I was initially licensed in Nevada during the second 6 months of the biennial period of registration (January 1, 2014 through June 30, 2014) and have completed a minimum of thirty (30) hours of AMA Category 1 CME, two (2) hours of which were in medical ethics or pain management and/or addiction care and twenty (20) hours of which were in my scope of practice or specialty.

__X__ I was initially licensed in Nevada during the third 6 months of the biennial period of registration (July 1, 2014 through December 31, 2014) and have completed a minimum of twenty (20) hours of AMA Category 1 CME, two (2) hours of which were in medical ethics or pain management and/or addiction care and eighteen (18) hours of which were in my scope of practice or specialty.

_____ I was initially licensed in Nevada during the fourth 6 months of the biennial period of registration (January 1, 2015 through June 30, 2015) and completed a minimum of ten (10) hours of AMA Category 1 CME, two (2) hours of which were in medical ethics or pain management and/or addiction care and eight (8) hours of which were in my scope of practice or specialty.

_____ I am exempt from submitting proof of completion of CME because I have completed a full year of residency or fellowship training during the biennial period of July 1, 2013 through June 30, 2015. **If you checked this statement, please attach a copy of proof of completion of your training.**

RENEWAL APPLICATION AFFIRMATION

BY SIGNING BELOW, I SWEAR OR AFFIRM UNDER PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.

_____ 06-12-15

Signature ***(Stamp Unacceptable)*** **Date**

RECEIVED

7/1/2013 - 6/30/2015 PHYSICIAN (M.D.)
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

Date Received by Board
SEP 08 2014
NEVADA STATE BOARD OF MEDICAL EXAMINERS (Board Use Only)

RECEIVED
License No.
AUG - 4 2014
File No.
NEVADA STATE BOARD OF MEDICAL EXAMINERS

1. Present Legal Name WILLIS (Last) DONALD (First) CLYDE (Middle) ( ) (Maiden)

List any other name(s) ever used

Address:
The Public Access Address will be available to the public on the Board's website, and will also be your contact address once licensed. It can be changed if the Licensee completes the Notification of Address Change form available on the Board's website: www.medboard.nv.gov.
The Mailing Address that you choose will be used for communication only during the application process. It can be one and the same.

2. Public Address SAME AS MAILING ADDRESS (Street) (City) (County) (State) (Zip)

☑ Please check if you choose to have your Mailing Address the same as the Public Address you have entered above.

3. Mailing Address 12197 So. STONERIDGE Cir. (Street) PARADISE, CA 95969 (City) BUTTE (County) CA (State) 95969 (Zip)

4. Telephone Numbers ( ) (Office) ( ) (Fax) ( ) (Home) (Cellular (Optional))

Email address willisdon@sbcglobal.net

5. Date of Birth /1943 (Month / Day / Year) Place of Birth CA USA (City, State, Country) Gender F (M)

6. Citizenship: (U.S. Citizen) Alien Registration # Employment Authorization # Visa

Submit a Certified Birth Certificate or original Certificate of Naturalization or current U.S. Passport or copy of the front and back of your Alien Registration card, Employment Authorization card or Visa. Please note: Copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

7. Social Security Number Color of Eyes Color of Hair Height Weight

NRS 630.197(1)(a) An applicant for the issuance of a license to practice medicine shall include the social security number of the applicant in the application submitted to the Board.
NRS 630.165(3) The applicant bears the burden of proving and documenting his qualifications for licensure.

NRS 630.173(2) The Board has the right to consider information for any malpractice history or disciplinary hospital privilege history that is more than 10 years old.

For the purposes of the following questions, these phrases or words have these meanings:

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

"Medical condition" includes physiological, mental or psychological condition or disorder.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR SIGNED WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR LICENSURE* FORM.

8. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? (If "Yes," attach explanation on separate sheet.) Yes (No) DW

9. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? (If "Yes," attach explanation on separate sheet.) Yes No (N/A) DW

10. If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? (If "Yes," attach explanation on separate sheet.) Yes No (N/A) DW

11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? (If "Yes," attach explanation on separate sheet.) Yes (No) DW

D. Willis, M.D.

12. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? (If "Yes," attach explanation on separate sheet.) (Yes) ____No DC

12a. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? (If "Yes," attach explanation on separate sheet.) (Yes) ____No DC

13. Have you EVER been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. (If "Yes," attach explanation on separate sheet.) ____Yes (No) DC

14. Have you previously applied for medical licensure in Nevada (including in a Residency program)? (If "Yes," attach explanation on separate sheet.) ____Yes (No) DC

15. List names and addresses of all medical schools attended. HAVE EACH MEDICAL SCHOOL SUBMIT AN OFFICIAL TRANSCRIPT DIRECTLY TO THE BOARD.

Medical School Name	City/State/Country	Place Where Instruction Received	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
INDIANA UNIV. School of Medicine	Indianapolis IN		08/1972 to 02/1976
Van Nuys Med. Science Bldg., 635 N. BARNHILL Drive # MS122 INDIANAPOLIS, IN 46202-5120			

(All information must begin on the application. If more space is needed, please attach separate sheet.)

16. Doctor of Medicine Degree granted by:

Medical School Name	City/State/Country	Exact Date of Issuance (Month/Day/Year)
INDIANA University	Indianapolis, IN USA	02/29/1976

17. List all ACGME* approved postgraduate medical education you have received as an Intern, Resident or Fellowship in the United States or Canada.
*Accreditation Council for Graduate Medical Education

Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
PGY1	Royal Jubilee Hospital	Victoria, BC, CANADA	I	Rotating	06-1976 to 06/1977
PGY 2, 3 + 4	STANFORD UNIVERSITY MEDICAL CNTR	STANFORD, CA 94305	R	OB-GYN	07/1977 to 07/1981 DM

(All information must begin on the application. If more space is needed, please attach separate sheet.)

18. List non-ACGME Fellowship training or non-ACGME combined postgraduate medical education attended in the United States or Canada.

If combined program list Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I =Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
∅					

(All information must begin on the application. If more space is needed, please attach separate sheet.)

19. Have you EVER been the subject of an investigation (including matters that resulted in no adverse action or outcome to you), have you resigned, been dismissed, or have any actions, form of remediation(s), restrictions, limitations, probations, terminations or any other disciplinary actions ever been imposed on you while participating in any type of training program? (If "Yes," attach explanation on separate sheet.) ____Yes (No) DM

20. If you graduated from a medical school located outside the United States of America or Canada, list your ECFMG#: N/A

Malpractice Questions:

12. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable?

Yes DW No

12a. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable?

Yes DW No

Malpractice Explanation(s):

List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If have not answered "yes" to questions #12 and/or #12a and do not have any such claims or suits, this section will be left blank. If you have more than 1 claim, make a copy or copies of this page and submit all explanations with your application for licensure.

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

Which court?
(If settled before initiation of civil action, state here.)

Current status of claim: DW

☐ Open ☒ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgment or settlement $

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☒ Primary defendant ☐ Co-defendant ☐ Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event: DW

Malpractice Questions:

12. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable?

Y Yes ____ No N/A

12a. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable?

Y Yes ____ No N/A

Malpractice Explanation(s):

List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If have not answered "yes" to questions #12 and/or #12a and do not have any such claims or suits, this section will be left blank. If you have more than 1 claim, make a copy or copies of this page and submit all explanations with your application for licensure.

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

Which court?
(If settled before initiation of civil action, state here.)

Current status of claim:

☐ Open ☒ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgment or settlement $

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ Primary defendant ☒ Co-defendant ☐ Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Malpractice Questions:

12. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? X Yes ___ No DW

12a. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? X Yes ___ No DW

Malpractice Explanation(s):

List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If have not answered "yes" to questions #12 and/or #12a and do not have any such claims or suits, this section will be left blank. If you have more than 1 claim, make a copy or copies of this page and submit all explanations with your application for licensure.

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

Which court?
(If settled before initiation of civil action, state here.)

Current status of claim: DW

☐ Open ☐ Closed (settled or judgment) ☒ Dismissed (no money paid out) ☐ Other

Amount of judgment or settlement $

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ Primary defendant ☐ Co-defendant ☒ Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Malpractice Questions:

12. Have you EVER been named as a defendant, or been requested to respond as a defendant in a litigation involving professional liability, or malpractice, including any military tort claims if applicable? X Yes ____No DW

12a. Have you EVER had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable? X Yes ____No DW

Malpractice Explanation(s):

List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If have not answered "yes" to questions #12 and/or #12a and do not have any such claims or suits, this section will be left blank. If you have more than 1 claim, make a copy or copies of this page and submit all explanations with your application for licensure.

Name of patient involved:

In which state did the action take place?

Case number (if applicable):

Which court?
(If settled before initiation of civil action, state here.)

Current status of claim:

☐ Open ☐ Closed (settled or judgment) ☒ Dismissed (no money paid out) ☐ Other

Amount of judgment or settlement $

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☒ Primary defendant ☐ Co-defendant ☐ Other

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

21. For each of the following licensing examinations, list the location, parts and dates taken, and scores obtained. (Also include failed examinations.) FOR EACH EXAM TAKEN, HAVE CERTIFICATE OF SCORES SUBMITTED FROM TESTING ENTITY DIRECTLY TO THE BOARD OFFICE.

RECEIVED
SEP 08 2014
NEVADA STATE BOARD OF MEDICAL EXAMINERS

21a. State Written Examination:
Location | Date (Mo./Yr.) | Results (Scores)

21b. NATIONAL BOARD (not ABMS Board certification): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)
NONE
Location | Part Taken | Date (Mo./Yr.) | Results (Two Digit Scores)
Indianapolis IN | I, II, III | 06-15-1977 | PASSED

(If more space is needed, please attach a separate sheet of paper.)

21c. FLEX (Federation Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)
Location | Date (Mo./Yr.) | Results (FLEX weighted average)

(If more space is needed, please attach a separate sheet of paper.)

21d. USMLE (United States Medical Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)
Location | Step Taken | Date (Mo./Yr.) | Results (Three Digit Scores) | Number of Attempts

(If more space is needed, please attach a separate sheet of paper.)

21e. LMCC (Licentiate of the Medical Counsel of Canada): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)
Location | Part Taken | Date (Mo./Yr.) | Results (Scores)

21f. SPEX (Special Purpose Examination):
Location | Date (Mo./Yr.) | Results (Scores)

22. State your scope of practice/specialty (ies) Abortion only OB GYN Limited to abortions only Possibly Surgical Assisting

23. List any and all certifications and re-certifications by a board or sub-board recognized by the AMERICAN BOARD OF MEDICAL SPECIALTIES (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS).

Specialty Board	If you are Lifetime Board Certified, indicate "Lifetime"	Certification #	Dates of Certification and/or Recertification (Mo./Yr.)
Am. Board OB GYN	Lifetime	19407	11-5-1982

VERIFICATION of LIFETIME STATUS
HAS BEEN REQUESTED from
Am. Board OB GYN to be sent
directly to NEVADA MEDICAL BOARD

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D. Gibbs M.D.

Donald C. Willis, MD

Addendum/correction to Question #21 B

NBME Part I Date taken 6-11-74 Score 78

NBME Part II Date taken 9-23-75 Score 82

NBME Part III Date taken 3-9-77 Score 81.2

24. Account for, in chronological order, all activities since graduation from medical school. **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.** (Curriculum Vitae cannot be submitted in lieu of your answer to this question.)

Activities	Location (City/State/Country)	From (Mo./Yr.)	To (Mo./Yr.)
(1) Rotating Internship	Royal Jubilee Hospital 1900 Fort Street Victoria, BC, Canada V8R 1J8	06/1976	06/1977

From 03-1976 to 06-1976 Time off between graduation from medical school and start of internship - No special activity DW

continued on separate sheet

(All information must begin on the application. If more space is needed, please attach separate sheet.)

25. List below the requested information for all hospitals or surgery centers in which you **ARE, OR HAVE EVER BEEN** a staff member at any level during the last ten years. If none, please indicate. Do not list internship, residency or fellowship affiliation.

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.)	To (Mo./Yr.)
Feather River Hospital	5974 Pentz Rd Paradise, CA 95969	09/2003	09/2007 and 04/2009 to 04/2009

(All information must begin on the application, if more space is needed, please attach separate sheet.)

26. List any and all licenses **YOU HOLD OR HAVE HELD** to practice medicine in any state, territory or country.

State/Territory Country	License #	Date of Issuance (Mo./Yr.)	Status
OREGON	MD 10994	1-12-78	Expired
CALIFORNIA	G35712	10-17-77	Active
ALASKA	4825	4-9-02	Surrendered
ALASKA Locum	2091	01-22-02	Expired

(All information must begin on the application, if more space is needed, please attach separate sheet.)

27. Have you EVER been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? ____Yes X No DW
(If "Yes," attach explanation on separate sheet.)

28. Have you EVER had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? X Yes ____No DW
(If "Yes," attach explanation on separate sheet.)

29. Have you EVER voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? X Yes No DW
(If "Yes," attach explanation on separate sheet.)

30. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization? ____Yes X No DW
(If "Yes," attach explanation on separate sheet.)

31. Have you EVER been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? ____Yes X No DW
(If "Yes," attach explanation on separate sheet.)

D. Willis, M.D.

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Donald C. Willis MD Continuation of question 24 page 4
All activities since medical school graduation

2. OBGYN Residency 07/1977 to 07/1980
Director of OBGYN Residency Program
Stanford Univ. School of Medicine
300 Pasteur Dr. HH333
Stanford, CA 94305-5317

3. OBGYN Practice 7-1980 to 7/1994 DW
Medical Staff Credentialing
Kaiser Permanente
500 NE Multnomah Street, Ste 100
Portland, OR 97232
(for office and hospial privileges info)

4. (07/1994) 05 1995 DW
02/1994 to 02/1995 DW
Relocated to California,
secured new position

5. Outpatient contract physician 05/1995 to 1/1996 DW
Two part-time positions
A. Planned Parenthood, San Mateo and Daly City
Contact Planned Parenthood Mar Monte
1691 The Alameda
San Jose, CA 95126

B. Pregnancy Consultation Center
Contact Forest O. Smith, MD, Medical Director
1393 Santa Rita Road #8
Pleasanton, CA 94566

6. Private Practice OBGYN 02/1996 to 07/1997
Office: 15899 Los Gatos-Almaden Rd. #1
Los Gatos, CA 95032
Hospital privileges
Good Samaritan Hospital P.O. Box 240002
San Jose, CA 95124

Community Hospital
Los Gatos, CA 95030

Los Gatos Surgery Center
Los Gatos, CA 95030

D. Willis M.D.

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7. High Desert Primary Care 07/1997 to 06/1999
Employed full-ime OBGYN
Admin 17091 Main St., Hesperia, CA 92345

8. OBGYN Private Practice 07/1999 to 12/2000
Offices:18484 Hwy 18, Ste 230
Apple Valley, CA 92307
and
18182 Hwy 18, Ste 101
Apple Valley, CA 92307

Hospital privileges same for #7 High Desert Primary care and #8 Private Practice (in continuity with no gaps)

St. Mary Medical Center
18300 Hwy 18, Apple VAlley, CA 92307
(Med Staff Office)

Victor Valley Comm Hospital
15248 11th St., Victorville, CA 92395

Apple Valley Surgical Center
Hwy 18
Apple Valley, CA 92307
Tel 760.946.1170

BARSTOW COMM. HOSPITAL
BARSTOW, CA 92311

Desert valley Hospial
16850 Bear Valley Rd., Victorville, CA 92392

9. U.S. Indian Health Service 12/2000 to 03/2001
Hastings Indian Hospital
100 Bliss Ave., Tahlequah, Oklahoma 74464

10. Private Practice OBGYN 04/2001 to 12/2001
Offices 18182 Hwy 18, Ste. 101
Apple Valley, CA 92307
and
801 Mountain View St., Ste C

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Barstow, CA 82311
Hospital Privileges
St. Mary Medical Center
18300 Hwy 18. Apple Valley, CA 92307
(Med Staff Office)

Victor Valley Comm. Hospital
15248 11th St., Victorville, CA 92395
Med Staff Office)
Barstow Comm. Hospital
Barstow, CA 92311
Med Staff Office)

11. Relocated to Alaska. for a locum. 12/2001 to 08/2003
After arrival, did not take position. Time off to select new position. Did not work in Alaska.

Alaska Native Medical Center
Anchorage, Alaska Tel 907.729.3188

12. Locum ~~tenens~~ for office of P.A.Dovre', MD 08/01/2003 to 08/30/2003
6283 Clark Rd., Ste 8 Paradise, CA 95969
No hospital privileges

13. Feather River Hospital Rural Health Clinic, 09/2003 to 09/2007
5974 Pentz Rd., Paradise, CA 95969
Hospital Privileges
Feather River Hospital
5974 Pentz Rd., Paradise, CA 95969

14. Family Healthcare Network 10/2007 to 03/2009
Employed OB/GYN practice 559.741.4500
~~400 E. Oak St.~~, Visalia, CA 93291
a. Hospital Privileges
Kaweah Delta Med Center 559.624.2000
400 W. Mineral King Ave. Visalia, CA 93291-6263
b. Hanford Consolidated Hospitals
c/o Adventist Medical Center
115 Mall Drive, Hanford, CA 93230

15. Locum fo P.A. Dovre', MD 04/2009 to 4/2009
Office 6283 Clark Rd., Ste 8 Paradise, CA 95969

5974 Pentz Rd., Paradise, CA 95969. Locum privileges
04/2009 TO 04/2009
Feather River Hospital

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16. Time off for thoughtful consideration of retirement. 04/2009 to 05/2010

17. Feminist Women's Health Centers
1442 Ethan Way, ste 200
Sacramento, CA 95825
07/2005 to09/2007
and
06/2010 to Present

Part-time employee for abortions. No hospital privileges

08-13-14

D. Willis, M.D.

32. Have you EVER surrendered your state or federal controlled substance registration or had it revoked, suspended, limited or denied? (If "Yes," attach explanation on separate sheet.) ____Yes X No DW

33. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any (all) resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)
FAIRBANKS MEMORIAL HOSPITAL	Fairbanks, AK 99701	DENIAL OF PRIVILEGES	08-07-2003
FRONTIER RIVER HOSPITAL	95959 SKYWAY PARADISE, CA	SUMMARY SUSPENSION OF PRIVILEGES	04-23, 2004

(All information must begin on the application, if more space is needed, please attach separate sheet.)

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this questions is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

Please place a check mark next to one of the following statements:

DW X (a) I am not subject to a court order for the support of a child;

____(b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; OR

____(c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.

DW X Yes ____No
DW

www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

SAFE INJECTION PRACTICE ATTESTATION

ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT PHYSICIANS

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to Chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.

http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

Applicant: _____ Date: 7-6-14

D. Willis, M.D.

COMMUNICATIONS AFFIRMATION

Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for physicians and physician assistants who practice medicine in the state of Nevada via telemedicine and whose physical presence exists outside the state of Nevada or the United States

I hereby agree that as a condition of obtaining or maintaining licensure with the Board, I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change, and that the failure to do so may subject me to a fine or disciplinary action as allowed in NRS 630.244.

Printed Name of Applicant/Licensee: DONALD C. WILLIS

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____ 08.13.14

Date: 12-17-2013

APPLICANT PHOTOGRAPH:

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

SIGN THE PHOTOGRAPH IN INK ACROSS THE LOWER PORTION OF ITS FRONT SIDE.

I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

_____ 12-17-2013
Signature of applicant Date

9-2-2014

D. Willis, M.D.

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APPLICATION AFFIRMATION

I, DONALD CLYDE WILLIS
(Print your full name)

being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application, as well as any and all further explanations contained on any separate attached pages, are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occurs prior to my being granted licensure to practice medicine in the state of Nevada.

8-27-14

Signature of applicant

12-17-2013
Date

HEIDI LANGE
Comm. #1915233
NOTARY PUBLIC CALIFORNIA
BUTTE COUNTY
My Commission Expires Dec. 4, 2014

(NOTARY SEAL)

State of California County of Butte
Subscribed and sworn to before me this 27th day of August, 2014
Notary Public for the State of California
My Commission Expires: Dec 4, 2014
Residing at: Paradise, CA
City State

Heidi Lange, Notary Public
Signature of Notary

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FORM B

LIST OF MALPRACTICE INSURANCE CARRIERS

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, list all malpractice carriers.

Name of Insured: DONALD C. WILLS, MD

Insurance Company: N.W. PERMANENTE - self-insured RAISER PERMANENT
Address: 500 NE MULTNOMAH St, #100
PORTLAND, OR 97232
Phone Number: 503.813.3850
Fax Number:
Policy Number: Self-insured
Dates: 07-1980 to 06-1994

Insurance Company: *Continued on Separate page
Address:
Phone Number:
Fax Number:
Policy Number:
Dates:

Insurance Company:
Address:
Phone Number:
Fax Number:
Policy Number:
Dates:

Insurance Company:
Address:
Phone Number:
Fax Number:
Policy Number:
Dates:

Insurance Company:
Address:
Phone Number:
Fax Number:
Policy Number:
Dates:

(If more space is needed, please copy this page or attach a separate sheet.)

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ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners
P.O. Box 7238, Reno, NV 89510
or
1105 Terminal Way, Ste 301, Reno, NV 89502

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during medical school or your postgraduate training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, ASK YOUR LICENSING SPECIALIST. Our licensing specialists are here to help you.

o o o o o

I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name DONALD C WILLIS

Sign your name _____

Date 07-21-2014

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a [illegible] responses provided to the Board in your application for licensure, and which occurs prior to [illegible] granted licensure to practice medicine in the state of Nevada.