ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org
Emails with attachments must be sent in PDF format to support@armedicalboard.org

Are you utilizing FCVS for your Arkansas license? ☑ Yes ☐ No
Are you a current or former member of the U.S. military or a spouse of a current or former member of the U.S. military? ☐ Yes ☑ No

APPLICATION FOR MEDICAL LICENSURE IN ARKANSAS
& Centralized Credentials Verification Service

1. Please read the IMPORTANT INFORMATION and ALL INSTRUCTIONS included in the application packet.
2. Type or print legibly (in dark blue or black ink) all application documents. (One sided documents only.)
3. Provide exact dates whenever possible, in *mm/dd/yyyy* format.
4. All questions must be answered. If a question does not apply to you, please write "n/a" in the space provided.
5. Give careful thought to each answer because you are certifying that the information you provide is truthful, complete and correct.
6. If you answer "Yes" to any question in Parts IV or V of the application, you MUST submit a signed and dated explanation.
7. Failure to answer all questions completely and accurately; omitting or falsifying information, may be cause for denial of your application or disciplinary action if you are subsequently granted a license. *When in doubt, disclose and explain all information.*

TYPE OF LICENSE YOU ARE APPLYING FOR (check one)

☑ Medicine/Surgery (MD) ☐ Osteopathic Medicine/Surgery (DO) ☐ Educational License

Are you requesting that a temporary license be issued prior to full licensure? ☐ Yes ☐ Not at this time

PART I - PERSONAL IDENTIFICATION INFORMATION

1a. Full Legal Name (Last, First, Middle, Suffix, Degree): PARKER, WILLIE JAMES

1b. Other Names Used (including Maiden Name): N/A

2a. Social Security Number:

2b. Driver's License State & Number: AL

2c. Gender: ☒ Male ☐ Female

2d. Date of Birth (mm/dd/yyyy): /

3a. Place of Birth: Birmingham, Alabama

3b. Country of Citizenship: United States

3c. Immigration Status (if not U.S. citizen): n/a

3d. How long have you been in the U.S.? (if not U.S. citizen): n/a

3e. Ethnicity: ☒ Non-Hispanic ☐ Hispanic

3f. Race: ☐ American Indian/Alaska Native ☐ Asian ☒ Black/African American ☐ White ☐ Hawaiian/Pacific Islander ☐ Hispanic

4a. Public Address (Street, City, State, Zip Code): 1223 26th Ave, North Hueytown, AL 35023

4b. Private Address (Street or PO Box, City, State, Zip Code):

4c. Private Phone #: n/a

4d. Work Phone #:

4e. Fax #:

4f. Mobile Phone #:

4g. Personal E-mail Address:

5a. If not currently living in Arkansas, do you plan to relocate? ☒ No ☐ Yes - Approx. date: _____

5b. Intended Practice Location in Arkansas: Name and Address of Hospital, Clinic, Group or Private Practice

5c. Will you be providing telemedicine services from outside the state of Arkansas? ☒ No ☐ Yes - Name of Telemedicine Contract Firm: _____ Phone _____

6a. NPI Number:

6b. Accept Medicaid/Medicare Patients? ☐ Medicare ☐ Medicaid ☐ Neither ☒ Unknown/Undecided

FOR ASMB USE ONLY

Name: Willie James Parker, M.D.
License Number:
License Issued:
Basis for License: Flex

Application Received: 1/17/2020
Fees Received: $ 500.00
Application Declined:
PHIDNo.: ASMB216820

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PART II - EDUCATION

MEDICAL SCHOOL EDUCATION

List all medical school(s) you attended (attach additional sheets if necessary). If you attended more than one medical school, provide the reason you changed medical schools on a separate sheet of paper, signed and dated by you. If you completed medical school in more or less than four years, provide the reason on a separate sheet of paper, signed and dated by you.

7a. Institution Name	7b. Country of Medical School
United University of Iowa College of Medicine	USA

7c. Mailing Address (Street Address, City, State/Country, Zip Code): 200 MAB 451 Newton Road Iowa City, IA 52242

7d. Start Date	7e. End Date	7f. Graduated?	7g. Degree Awarded
06/01/1986	05/04/1990	☑ Yes ☐ No	☑ M.D. (or foreign equivalent) ☐ D.O. ☐ None

8a. Institution Name	8b. Country of Medical School

8c. Mailing Address (Street Address, City, State/Country, Zip Code):

8d. Start Date	8e. End Date	8f. Graduated?	8g. Degree Awarded
/ /	/ /	☐ Yes ☐ No	☐ M.D. (or foreign equivalent) ☐ D.O. ☐ None

POSTGRADUATE EDUCATION, US OR FOREIGN

List internships, residencies, fellowships and other postgraduate training chronologically (attach additional sheets if necessary). If you did not complete a program or changed schools between years, provide the reason on a separate sheet of paper, signed and dated by you. If program still in process, enter anticipated completion date as end date.

9a. Full Name of Training Program: University of Cincinnati Medical Center
9b. Program ID (if known):
9c. Program Type (Internship, Residency, etc): Residency
9d. Specialty/Subspecialty: Obstetrics + Gynecology
9e. Department Name: Obstetrics + Gynecology
9f. Mailing Address (Street Address, City, State/Country, Zip Code): MSB Room 4505, 231 Albert Sabin Way MLO526 Cincinnati, OH 45267

9g. Start Date	9h. End Date	9i. Anticipated End Date	9j. Completed?	9k. Chief resident?
07/01/1990	06/30/1994	/ /	☑ Yes ☐ No ☐ In Process	☑ Yes ☐ No

9a. Full Name of Training Program: University of California San Francisco Prev. Medicine Residency
9b. Program ID (if known):
9c. Program Type (Internship, Residency, etc): Residency
9d. Specialty/Subspecialty: Preventive Medicine
9e. Department Name: Preventive Medicine
9f. Mailing Address (Street Address, City, State/Country, Zip Code): 550 16th Street, Second Floor San Francisco, CA 94158

9g. Start Date	9h. End Date	9i. Anticipated End Date	9j. Completed?	9k. Chief resident?
07/01/2000	06/30/2001	/ /	☑ Yes ☐ No ☐ In Process	☐ Yes ☑ No

9a. Full Name of Training Program: University of Michigan Fellowship in Family Planning
9b. Program ID (if known):
9c. Program Type (Internship, Residency, etc): Family Planning Fellowship
9d. Specialty/Subspecialty: Family Planning
9e. Department Name: Obstetrics + Gynecology
9f. Mailing Address (Street Address, City, State/Country, Zip Code): L4001 Women's Hospital 1500 East Med. Ctr Drive Ann Arbor, MI 48109

9g. Start Date	9h. End Date	9i. Anticipated End Date	9j. Completed?	9k. Chief resident?
07/01/2006	06/30/2008	/ /	☑ Yes ☐ No ☐ In Process	☐ Yes ☑ No

9a. Full Name of Training Program:
9b. Program ID (if known):
9c. Program Type (Internship, Residency, etc):
9d. Specialty/Subspecialty:
9e. Department Name:
9f. Mailing Address (Street Address, City, State/Country, Zip Code):

9g. Start Date	9h. End Date	9i. Anticipated End Date	9j. Completed?	9k. Chief resident?
/ /	/ /	/ /	☐ Yes ☐ No ☐ In Process	☐ Yes ☐ No

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EXAMINATION HISTORY Please specify exam series USMLE, NBME, FLEX, NBOME, COMLEX, LMCC (or State Exam prior to 1975). *If you failed any step of any examination, even once, you must submit a separate, signed and dated explanation of the circumstances.* Attach additional sheets if necessary.

10a. Exam Series & Step	10b. Number of Attempts	10c. Number of times failed	10d. Date PASSED
Flex	1	0	06/2/1990
			/ /
			/ /
			/ /

10e. Have you ever taken the SPEX or COMVEX examination? ☐ Yes ☑ No If Yes, you must provide a signed and dated explanation.

11a. If you are an International medical graduate, do you hold an ECFMG certification? ☐ Yes ☐ No ☑ N/A (If No, you must provide a signed and dated explanation)	11b. ECFMG Certificate No.	11c. Date Issued
		/ /

SPECIALTY/ BOARD CERTIFICATION Please list all specialties, including self-designated. Attach additional sheets if necessary.

12a. Primary Practice Specialty/Subspecialty	12b. Board Certified?	12c. Certification Type	
Obstetrics + Gynecology	☑ Yes ☐ No	☐ Lifetime ☐ Time-Limited ☑ MOC	
12d. Name of Specialty Board, if certified	**12e. Certification Date**	**12f. Recertification Date**	**12g. Expiration Date**
American Board of Ob-Gyn	11/20/1996	12/10/2019	12/31/2020
13a. Secondary Specialty/Subspecialty	**13b. Board Certified?**	**13c. Certification Type**	
Preventive Medicine	☐ Yes ☑ No	☐ Lifetime ☐ Time-Limited ☐ MOC	
13d. Name of Specialty Board, if certified	**13e. Certification Date**	**13f. Recertification Date**	**13g. Expiration Date**
American Board of Preventive Med.	1/1/19	/ /	/ /
14a. Tertiary Specialty/Subspecialty	**14b. Board Certified?**	**14c. Certification Type**	
Family Planning	☐ Yes ☑ No	☐ Lifetime ☐ Time-Limited ☐ MOC	
14d. Name of Specialty Board, if certified	**14e. Certification Date**	**14f. Recertification Date**	**14g. Expiration Date**
Amer Board of Ob-Gyn			

PART III - PROFESSIONAL ACTIVITIES

PROFESSIONAL LICENSURE List all states or territories of the United States or other countries in which you **hold** or **have ever held** a medical license. Include all temporary, instructional and training permits/licenses. Attach additional sheets if necessary. If none, enter "N/A."

15a. Jurisdiction (State, Country)	15b. License No.	15c. Issue Date	15d. Expiration Date	15e. Current Status
California, USA	A053102	05/1/1994	10/31/2009	Expired
Hawaii, USA	11733	10/11/2001	01/31/2010	expired
Ohio, USA	35063458	05/29/1992	04/01/2010	expired
Michigan, USA	4301087686	05/08/2006	01/31/2010	expired
Washington, DC, USA	MD03746	06/30/2008	02/28/2013	expired
Maryland, USA	D0069574	07/15/2009	09/30/2013	expired
Virginia, USA	0101246274	08/13/2009	10/31/2012	expired
Pennsylvania, USA	MD441490	11/09/2009	12/31/2016	expired

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Professional Licensure Addendum

	License #	Issue Date	Expiration Date	Status
· Illinois	#036131869	12/2012	07/31/2018	expired
· Mississippi	# 22028	05/2012	06/30/2017	expired
· Alabama	#MD 031662	05/2012	12/31/2020	active
· New Jersey	#25 MA 091115000	05/2012	06/30/2013	expired
· Iowa	#28574	03/1992	10/01/1994	expires
· Georgia	#071442	02/2014	10/31/2017	expired

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Addendum to Page 2 of 2

MILITARY SERVICE Submit a copy of your separation papers (DD Form 214) with your application. If Active Duty, have the Verification of Current Military Service sent to this office or have your current Commanding Officer submit a verification letter directly to this office.

16a. Have you ever been in the armed forces? ☐ Yes ☑ No

16b. Country & Branch of Service	16c. Date of Entry	16d. Date of Discharge	16e. Type of Discharge
N/A	/ /	/ /	
N/A	/ /	/ /	

WORK HISTORY Please provide a chronological listing for all medical and non-medical work history and other activities, including hospitals, faculty appointments, private practice, employment corporations, military assignments, government agencies, locum tenens and telemedicine assignments, and leaves of absence since graduation from medical school. Do not include Medical School or Postgraduate Education/Training. **Do not write, "See CV;" you must complete this section AND attach your curriculum vitae. If none, enter "N/A."**

17a. Date From: 06/01/2016 | 17b. Date To: / / Present | 17c. Type of Affiliation, (Primary or Previous Practice, Employment, Staff Appointment, etc.): Employment, Staff Physician Independent Contractor

17d. Name of Institution/Facility: Alabama Womens Center ☑ Primary Practice ☐ Previous

Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 4831 Sparkman Dr, NW Huntsville, AL 35810

17f. Title/Position/Staff Category: Physician, Independent Contractor | 17g. Specialty practiced or granted privileges in: Gynecology

17a. Date From: 01/01/2014 | 17b. Date To: / / Present | 17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.): Independent Contractor

17d. Name of Institution/Facility: West Alabama Womens Center ☐ Primary Practice ☑ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 535 Jack Warner Pkwy, Suite I Tuscaloosa, AL 35404

17f. Title/Position/Staff Category: Physician, Independent Contractor | 17g. Specialty practiced or granted privileges in: Gynecology

17a. Date From: 07/01/2013 | 17b. Date To: 08/30/2017 | 17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.): Independent Contractor

17d. Name of Institution/Facility: Atlanta Women's Center ☐ Primary Practice ☑ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 235 W. Wieuca Rd, NE Atlanta, GA 30342

17f. Title/Position/Staff Category: Contractor | 17g. Specialty practiced or granted privileges in: Gynecology

17a. Date From: 07/01/2012 | 17b. Date To: 05/01/2016 | 17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.): Independent Contractor

17d. Name of Institution/Facility: Reproductive Health Services ☐ Primary Practice ☑ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 811 South Perry Street Montgomery, AL 36104

17f. Title/Position/Staff Category: Contractor | 17g. Specialty practiced or granted privileges in: Gynecology

17a. Date From: 06/01/2012 | 17b. Date To: 04/01/2016 | 17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.): Independent Contractor

17d. Name of Institution/Facility: Jackson Women's Health Organization ☐ Primary Practice ☑ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 2903 North State Street Jackson, MS 39216

17f. Title/Position/Staff Category: contractor | 17g. Specialty practiced or granted privileges in: gynecology

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WORK HISTORY, continued

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
01/01/2012	12/31/2014	Practice

17d. Name of Institution/Facility: Family Planning Associates, Chicago — ☐ Primary Practice ☑ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 659 W. Washington Blvd Chicago, IL 60661

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Associate Medical Director	Gynecology

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
07/01/2010	12/30/2015	Practice

17d. Name of Institution/Facility: Philadelphia Women's Center — ☐ Primary Practice ☑ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 777 Appletree Street 7th Floor Philadephia, PA 19106

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Independent Contractor	Gynecology

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
06/01/2009	07/01/2011	Practice

17d. Name of Institution/Facility: Planned Parenthood Metropolitan Washington DC — ☐ Primary Practice ☑ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 1225 4th Street, NE Washington DC 20002

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Medical Director	Gynecology

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
07/01/2008	05/30/2009	Staff Appointment

17d. Name of Institution/Facility: Washington Hospital Center — ☐ Primary Practice ☑ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 110 Irving Street, NW

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Division Director	Gynecology + Obstetrics

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
01/01/2002	06/30/2006	Faculty Appointment

17d. Name of Institution/Facility: Queens Medical Center — ☐ Primary Practice ☑ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 1301 Punchbowl Street Honolulu HI 98613

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Assistant Professor	Obstetrics + Gynecology

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
07/01/2001	07/01/2002	Employment

17d. Name of Institution/Facility: CA Dept of Health Services — ☐ Primary Practice ☑ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): PO Box 997377 MS 0500 Sacramento, CA 95899-7377

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Section Chief Epi + Evaluation	Epidemiology

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WORK HISTORY, continued

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
07/01/1998	06/30/2000	CDC Epidemic Intelligence Service

17d. Name of Institution/Facility: CA Dept of Health Service, MCH Branch — ☐ Primary Practice ☐ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 1615 Capitol Ave 5th Floor Sacramento CA 95899

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Medical Epidemiologist	Epidemiology

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
07/01/1994	06/01/1997	Staff Appointment

17d. Name of Institution/Facility: Merced Community Medical Center — ☐ Primary Practice ☑ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code): 333 Mercy Ave Merced CA 95340

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in
Staff Physician,	OB-GYN

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
07/01/1994	06/01/1997	

17d. Name of Institution/Facility — ☐ Primary Practice ☐ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
/ /	/ /	

17d. Name of Institution/Facility — ☐ Primary Practice ☐ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
/ /	/ /	

17d. Name of Institution/Facility — ☐ Primary Practice ☐ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in

17a. Date From	17b. Date To	17c. Type of Affiliation (Practice, Employment, Staff Appointment, etc.)
/ /	/ /	

17d. Name of Institution/Facility — ☐ Primary Practice ☐ Previous Practice

17e. Institution Mailing Address (Street or PO Box, City, State/Country, Zip Code)

17f. Title/Position/Staff Category	17g. Specialty practiced or granted privileges in

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FEDERAL DEA & STATE-ISSUED CONTROLLED SUBSTANCE REGISTRATIONS

List all current and previous Federal DEA and state-issued controlled substance registrations. If none, enter N/A.

18a. DEA or State Registration #	18b. State	18c. Your Address Associated with this Registration	18d. Expiration Date
	AL	4831 Sparkman Dr. NW Huntsville AL 35810	03 / 31 / 2019
	AL	4831 Sparkman Dr. NW Huntsville AL 35810	03 / 31 / 2022
			/ /
			/ /
			/ /
			/ /

TIME GAPS

Please provide an explanation for ALL time gaps of 30 days or more since the start of medical school. If none, enter N/A.

19a. Did you have a time gap in excess of 30 days between medical school and post-graduate training? ☐ Yes ☑ No

19b. Dates of time gap

19c. Explanation for time gap: (e.g. traveling, vacation, moving, prepared for residency)

19d. Additional time gap. Provide dates and explanation.

19e. Additional time gap. Provide dates and explanation. Use additional sheets if necessary.

MALPRACTICE CLAIMS

List all malpractice claims ever filed against you, regardless of disposition. If none, enter "n/a". Use additional sheets if necessary.

20a. Date of Claim	20b. Jurisdiction	20c. Disposition (Dismissed, Settled, Pending, etc.)	20d. Amount of Settlement Paid
01 / 30 / 1995	CA	Dismissed	$ 0
11 / 05 / 2005	Hawaii	Dismissed	$ 0
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$
/ /			$

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PART IV - ATTESTATION QUESTIONS

21. Do you currently maintain individual or group Professional Liability Insurance (malpractice) coverage? ☑ No ☐ Yes
If no, list reason: _____
Insurance Carrier Name: _____
Policy Number(s): _____
Expiration Date: _____ Coverage Amounts: _____
If Group policy, list group name: _____

SPECIAL INSTRUCTIONS FOR QUESTIONS 22-44

- **Please mark the appropriate box next to each question. Do not leave any questions blank.**
- **For each "Yes" response to questions 22-44, you must provide a separate, signed and dated statement giving full details including date, location, type of action, organization or parties involved, and specific circumstances.** If you are not sure about how to respond to a question, it is best to disclose and provide an explanation.
- **Failure to answer these questions accurately may result in disciplinary action or denial of license application.**
- Confidentiality: The contents of licensing files are generally considered public records under the Freedom of Information Act. If you believe that the additional information you are attaching to explain a "Yes" answer should be considered confidential, state that in the attachment. Be advised, however, that not all requests for confidentiality can be granted.

22. Has your application for examination or licensure ever been rejected, denied or withdrawn? *If yes, explain.* ☑ No ☐ Yes

23. Has any medical licensing board ever placed your license on probation, suspension, or has it revoked a license or certificate it had granted you? *If yes, explain and provide name and address of Board.* ☑ No ☐ Yes

24. Have you ever been ordered to appear before a state medical board for any reason other than licensure? *If yes, explain.* ☑ No ☐ Yes

25. Has a medical board or hospital ever initiated disciplinary procedures against you? *If yes, explain.* ☑ No ☐ Yes

26. Have your privileges at any hospital ever been denied, suspended, diminished, voluntarily or involuntarily relinquished, revoked or not renewed, or is any such action pending? *If yes, explain.* ☑ No ☐ Yes

27. Have you ever voluntarily surrendered your medical license in any state? *If yes, explain.* ☑ No ☐ Yes

28. Since the start of medical school, have you been charged or convicted (including a plea of nolo contendere) of a misdemeanor or felony (including DWI (Driving While Intoxicated) or DUI (Driving Under the Influence)? (NOTE: ***You must answer "Yes" even if records, charges, or convictions have been pardoned, expunged, plead down, released, or sealed.***) *If yes, explain.* ☑ No ☐ Yes

29. Have you ever been denied provider participation in any state or federal Medicaid program? *If yes, explain.* ☑ No ☐ Yes

30. Have you ever been warned, censured by, or requested to withdraw from any hospital in which you have been trained, been a staff member, or held hospital privileges? *If yes, explain.* ☑ No ☐ Yes

31. Have you ever been disciplined or dismissed from any professional activity or training program? Have you ever received a warning, reprimand, or been placed on probation during an internship, residency, or fellowship program? *If yes, explain.* ☑ No ☐ Yes

32. Have you ever voluntarily or involuntarily left a training institution program before completing it? *If yes, explain.* ☑ No ☐ Yes

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PART IV - ATTESTATION QUESTIONS, continued

33. Have you ever been reported to the National Practitioner Data Bank or subject to NPDB adverse action reporting? *If yes, explain.* ☑ No ☐ Yes

34. Have you ever resigned or surrendered clinical privileges from any medical staff while under investigation for possible incompetence or improper professional conduct, or in return for such an investigation not being conducted? *If yes, explain.* ☑ No ☐ Yes

35. Have you ever been denied membership, renewal thereof, or been subject to disciplinary action in any medical organization, or is any such action pending? *If yes, explain.* ☑ No ☐ Yes

36. Have you ever been terminated, sanctioned, penalized or had to repay money to any State Medicaid or Federal Medicare/Medicaid program? *If yes, explain.* ☑ No ☐ Yes

37. Have you ever been cited by a peer review organization? *If yes, explain.* ☑ No ☐ Yes

38. Have you ever had to discontinue practice for any reason for a period longer than one (1) month? *If yes, explain.* ☑ No ☐ Yes

39. Since the age of 21, have you been, or are you currently, being treated for alcoholism or substance abuse in an inpatient or outpatient setting? *If yes, explain.* ☑ No ☐ Yes

    39a. If Yes, was this the result of a medical board action? N/A ☐ No ☐ Yes

40. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine or to perform professional or medical staff duties in a competent, ethical, and profession manner? *If yes, explain.* ☑ No ☐ Yes

41. Are you currently being, or have you ever been monitored by a Physicians Health Committee in any state? *If yes, explain, and ask the Physician Health Committee to send documentation of your status.* ☑ No ☐ Yes

42. Has your license to practice medicine or Drug Enforcement Administration registration in any jurisdiction been denied, reduced, limited, suspended, revoked, placed on probation, not renewed voluntarily, or involuntarily relinquished, or is any such action pending? *If yes, explain.* ☑ No ☐ Yes

43. Have you ever defaulted on any Health Education Assistance loan? *If yes, explain.* ☑ No ☐ Yes

44. To your knowledge, are you currently the subject of an investigation by any licensing board as of the date of this application? *If yes, explain.* **If, during the application process, you become aware of any such investigation, you are required to report it to this office.** ☑ No ☐ Yes

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PART V - AFFIDAVIT OF APPLICANT

I, the undersigned applicant, after being duly sworn, hereby certify that I have read the complete application and know the full content thereof. I declare, under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true, correct, current, and complete to the best of my knowledge. I attest that I am the lawful holder of the degree of Doctor of Medicine or Doctor of Osteopathy, and that said degree was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware. I certify that the photograph that appears below is a true likeness of me, taken within the past sixty (60) days. I understand that any falsification or misrepresentation of any item or response in this application, or any documentation supporting this application, even if submitted separately, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice medicine in the State of Arkansas.

Amy Parker MD, MPH

Applicant's Signature (in ink)
(must be signed in the presence of a Notary Public)

01/10/2020

Date Signed
(must include the month, day and year signed)

SUBSCRIBED AND SWORN TO before me, a Notary Public in and for the State of Texas, this 10 day of January, 20 20.
(Notary date must be the same as the applicant's signature date above)

MICHAEL BIRKERT
Notary Public, State of Texas
Comm. Expires 03-19-2023
Notary ID 131937582

My commission expires: 03-19-2020

Notary Signature
(Notary seal must be below the photograph at left)

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

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PRACTITIONER PROFILE

Prepared for: Arkansas State Medical Board As of Date:1/23/2020

Practitioner Name: Parker, Willie James

ABMS® CERTIFICATION HISTORY

Certifying Board: American Board of Obstetrics and Gynecology
Certificate: Obstetrics and Gynecology
Certification Type: General
Certification Status: Certified
Participating in MOC: Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	Time Limited	12/31/2019	12/31/2020		Recertification	12/27/2019
Active	Time Limited	12/31/2018	12/31/2019		Recertification	12/27/2019
Expired	Time Limited	12/31/2017	12/31/2018		Recertification	12/27/2019
Expired	Time Limited	12/31/2016	12/31/2017		Recertification	12/27/2019
Expired	Time Limited	12/31/2015	12/31/2016		Recertification	12/27/2019
Expired	Time Limited	12/31/2014	12/31/2015		Recertification	12/27/2019
Expired	Time Limited	12/31/2013	12/31/2014		Recertification	12/27/2019
Expired	Time Limited	12/16/2012	12/31/2013		Recertification	12/27/2019
Expired	Time Limited	12/31/2011	12/31/2012		Recertification	12/27/2019
Expired	Time Limited	12/31/2010	12/31/2011		Recertification	12/27/2019
Expired	Time Limited	12/31/2009	12/31/2010		Recertification	12/27/2019
Expired	Time Limited	12/31/2008	12/31/2009		Recertification	12/27/2019
Expired	Time Limited	12/31/2007	12/31/2008		Recertification	12/27/2019
Expired	Time Limited	12/31/2006	12/31/2007		Recertification	12/27/2019
Expired	Time Limited	11/15/1996	12/31/2006		Initial	12/27/2019

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AOA® CERTIFICATION HISTORY

No AOA Certifications found.

ENTERED JAN 24 2020

PLEASE NOTE: For more information regarding the above data, please contact the reporting board or reporting agency. The information contained in this report was supplied by the respective state medical boards and other reporting agencies. The Federation makes no representations or warranties, either express or implied, as to the accuracy, completeness or timeliness of such information and assumes no responsibility for any errors or omissions contained therein. Additionally, the information provided in this profile may not be distributed, modified or reproduced in whole or in part without the prior written consent of the Federation of State Medical Boards.

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FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

VERIFICATION OF MEDICAL EDUCATION

(This form must be completed by the medical school)

INSTRUCTIONS TO THE DEAN

The individual identified on the attached Authorization For Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution. **Please complete this form and forward it to FCVS in the enclosed postage-paid, self-addressed envelope.**

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover. **If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).**

VERIFICATION OF MEDICAL EDUCATION

Name of Institution: University of Iowa College of Medicine

Complete Address:

Street Address: 1216 MERF

City: Iowa City **State:** IA **ZIP Code (Postal Code):** 52242

If name of Institution was different when this individual attended, please note this name below:

Premedical Education:

Years of education required for admission to your medical school: 4

Credential/degree presented by the applicant for admission to your medical school: B.A.

Enrollment and Participation: Our records indicate that Parker, Willie, James (type/print individual's name: Last, First, Middle, Suffix)

attended our medical school for total of 164 weeks of medical education on the following dates (mm/dd/yy):

From 06 (Month), 09 (Date), 86 (Year) **To** 05 (Month), 04 (Date), 90 (Year)

This individual (check one):

Was awarded the degree of Doctor of Medicine on 05 (Month), 04 (Date), 90 (Year)

Was NOT awarded a degree because:
(please explain - attach additional pages if necessary)

Certification: By my signature, I, Larissa Heimer (type/print name), certify that the above information is an accurate account of the above named individual's official records maintained in this and is true and correct to my knowledge.

ENTERED
JAN 29 2020

SEAL VERIFIED
Affix Institutional Seal Here. If no seal is available, this form must be notarized

Signature: Larissa Heimer

Title: Student Programs & Records

Date of Signature: 6-9-08

Phone: (319) 335-6823 **Fax:** (319) 335-8643

Email: annette-griffin@uiowa.edu

VERIFICATION OF MEDICAL EDUCATION

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation (attach additional pages as necessary).

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education?
   Response YES ☐ NO ☒

   If YES, please select the reason(s) for, indicate the dates of the interruption(s) or extension(s) and check whether the interruption/extension was approved or unapproved.

	From Mo/Yr	To Mo/Yr	Approved	Unapproved
Personal/Family			☐	☐
Academic remediation			☐	☐
Health			☐	☐
Financial			☐	☐
Participation in joint degree Program (e.g., MD/PhD)			☐	☐
Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
Participation in non-degree research			☐	☐
Other			☐	☐

   Please Specify: _____

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education?
   Response YES ☐ NO ☒

   If YES, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation and attach additional documentation to this report.

	From Mo/Yr	To Mo/Yr
Academic Probation		
Probation for unprofessional conduct/behavioral		
Probation for other reason		

   Please specify reason: _____

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university?
   Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university?
   Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?
   Response YES ☐ NO ☒

   If YES, please provide detailed documentation/information about the nature of the limitations or special requirements.

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Medical School

Medical Professional Name: Parker, Willie James

University of Iowa Carver College of Medicine

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Parker, Willie James

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Federation Credentials Verification Service (FCVS)

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Verification of Graduate Medical Education

Institution: University Hospital/University of Cincinnati College of

Specialty: Obstetrics and Gynecology

Address: Cincinnati, OH

Attention: OBSTETRICS AND GYNECOLOGY

Affiliated University: University of Cincinnati College of Medicine

Verification For:

Name: Parker, Willie James

Individual's Name on Record (If different from above):_____

Program Participation:

Important: Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Training Level: 1-4 (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Obstetrics and Gynecology
From: 07/01/1990 **To:** 06/30/1994
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: _____
From: / / **To:** / /
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: _____
From: / / **To:** / /
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

_____

_____

ENTERED JAN 29 2020

Certification:

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Affix your institutional seal in this space. If no seal is available, you must have this card signed

ELECTRONIC SEAL VERIFIED

Name: Kellie Flood-Shaffer, MD

Signature: Kellie Flood-Shaffer, MD

Title of Signatory: Residency Program Director (e.g., Program Director)

Date of Signature: 12/31/2013

Tel: 513-558-7653 Fax: 513-558-3558 E-Mail: floodskf@ucmail.uc.edu

Rev. 12/23/2013

FCVS ID: 91393 FID: 206149312 CODE: 113620

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Graduate Medical Education

Medical Professional Name:	Parker, Willie James
Accreditation ID:	2203821229
Institution:	University of Cincinnati Medical Center/College of Medicine Program
Specialty:	Obstetrics & Gynecology

Unusual Circumstances

Training Period: 7/1/1990 - 6/30/1994 **Residency**

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Parker, Willie James

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DATE OF REQUEST: 02/01/2020

VERIFICATION OF POSTGRADUATE TRAINING

PART I – PROGRAM NAME AND MAILING ADDRESS - PART I AND PART II TO BE FILLED OUT BY APPLICANT-REQUIRED FOR VERIFICATION TO BE ACCEPTED

PGE Program Name: Harvard School of Public Health
Dept. or Program Director: JoAnn Wilson-Singleton, Registrar
Address Line 1: 677 Huntington Avenue
Address Line 2: Kresge G-4
City, State, ZIP Code: Boston, MA 02115

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
Parker, Willie James		/ /
Other Names Used		Date of Completion (mm/dd/yyyy) 06/02/1998

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature: Parker
Date Signed (mm/dd/yyyy): / /

PART III – VERIFICATION (TO BE COMPLETED BY PROGRAM DIRECTOR OR AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Postgraduate Training Program: Harvard School of Public Health
Chief Resident? ☐ Yes ☐ No Date _____

Type of Program
☐ Internship ☐ Residency ☐ Clinical Fellowship ☐ Research Fellowship ☐ Assistantship ☐ Clerkship ☐ Externship
☐ Observership ☑ Other (please specify): Master of Public Health

Date Training Began	Date Training Ended or Anticipated Completion Date	Program Specialty or Subspecialty
7/1/1997	6/4/1998	Family and Community Health

If program was completed in more or less than the customary program length, please provide explanation (use additional sheets if necessary).

Was program completed successfully? *[If No, please explain (use additional sheets if necessary)]* ☐ In Process ☑ Yes ☐ No

During the program, was this physician ever investigated or disciplined for any reason? ☐ Yes ☑ No
[Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted or otherwise disciplined. If you respond "Yes" to this question, please provide copies of the training records/evaluations and summary letter from the Program Director.]

PART IV - VERIFIED BY

Verification provided by (Signature): [signature]
Signature Date: 2/11/2020

Type or legibly print name: Nathaniel Smith
Position/Title: Registrar's Office Liaison
ENTERED FEB 12 2020

Phone Number: 617-432-5104
Fax Number: 617-432-2009
E-mail Address: nvsmith@hsph.harvard.edu

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL

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Federation Place, P.O. Box 619850, Dallas, TX 75261-9850
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Postgraduate Medical Education

Institution: University of California, San Francisco
Address: Division of Preventive Medicine and Public Health
San Francisco, California 94105

Attention: **Program Director**
Affiliated University: University of California (San Francisco) School of Medicine

Verification For: Name: Parker, Willie James

Individual's Name on Record (If different from above): _____

Program Participation:

Important: Report incomplete postgraduate years (PGY) separate from those that were successfully completed.

If the postgraduate year is currently in progress report the expected completion date in the "To" field

Report internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

PGY: 6 — Specialty/Subspecialty: General Preventive Medicine & Public Health
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
From: 07/01/2000 To: 06/30/2001
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: _____ — Specialty/Subspecialty: _____
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
From: ___/___/___ To: ___/___/___
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

PGY: _____ — Specialty/Subspecialty: _____
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
From: ___/___/___ To: ___/___/___
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

ENTERED JAN 29 2020

ELECTRONICALLY SEAL VERIFIED

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this form notarized

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director (M.D./D.O. only).

Name: George W. Rutherford, M.D.
Signature: *George W. Rutherford, M.D.*
Title: Program Director
Date of Signature: June 12, 2009
Tel: (415) 597-9108 Fax: (415) 597-8299 E-Mail: grutherford@psg.ucsf.edu

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Graduate Medical Education

Medical Professional Name:	Parker, Willie James
Accreditation ID:	3800532008
Institution:	University of California (San Francisco)/University of California School of Publ
Specialty:	Preventive Medicine

Unusual Circumstances

Training Period: 7/1/2000 - 6/30/2001 **Residency**

Did you have any interruption(s) or extension(s) in your medical education?	**No**
Were you ever placed on probation?	**No**
Were you ever disciplined or placed under investigation?	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	**No**

End of Applicant Reported Unusual Circumstances report for: Parker, Willie James

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DATE OF REQUEST: 2/20/20

VERIFICATION OF POSTGRADUATE TRAINING

PART I – PROGRAM NAME AND MAILING ADDRESS - PART I AND PART II TO BE FILLED OUT BY APPLICANT- REQUIRED FOR VERIFICATION TO BE ACCEPTED

PGE Program Name: University of Michigan Program
Dept. or Program Director:
Address Line 1: 1500 East Medical Center Drive
Address Line 2:
City, State, ZIP Code: Ann Arbor, MI 48109

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
Parker, Willie James, MD.	-	
Other Names Used		Date of Completion (mm/dd/yyyy) 06/30/2008

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
See attached A&R	/ /

PART III – VERIFICATION (TO BE COMPLETED BY PROGRAM DIRECTOR OR AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Postgraduate Training Program: Fellowship in Family Planning
Chief Resident? ☐ Yes ☒ No Date _____

Type of Program
☐ Internship ☐ Residency ☒ Clinical Fellowship ☐ Research Fellowship ☐ Assistantship ☐ Clerkship ☐ Externship
☐ Observership ☐ Other (please specify) _____

Date Training Began	Date Training Ended or Anticipated Completion Date	Program Specialty or Subspecialty
7/1/2006	6/30/2008	Family Planning

If program was completed in more or less than the customary program length, please provide explanation (use additional sheets if necessary).

Was program completed successfully? *[If No, please explain (use additional sheets if necessary)]* ☐ In Process ☒ Yes ☐ No
Dr. Parker was an exemplary fellow.

During the program, was this physician ever investigated or disciplined for any reason? ☐ Yes ☒ No
[Disciplinary actions include but are not limited to being placed on probation, issued a letter of reprimand, censured, suspended, restricted or otherwise disciplined. If you respond "Yes" to this question, please provide copies of the training records/evaluations and summary letter from the Program Director.]

PART IV – VERIFIED BY

Verification provided by (Signature)	Signature Date
Lisa H. Harris	2/20/2020
Type or legibly print name: Lisa H. Harris, MD, PhD	Position/Title: Professor of OB-Gyn, Director, Fellowship in Family Planning
Phone Number: 734-232-3897 / Fax Number:	E-mail Address: lhharris@med.umich.edu

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL

(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

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CW
FEB 21 2020

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: Arkansas State Medical Board As of Date:1/23/2020

PRACTITIONER INFORMATION

Name:	Parker, Willie James
Medical School:	University of Iowa Carver College of Medicine Iowa City, Iowa, UNITED STATES
Year of Grad:	1990
Degree Type:	MD

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI	NPI Type	Deactivation Date	Reactivation Date	Last Reported
1841203536	Individual			06/04/2018

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JAN 24 2020

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PRACTITIONER PROFILE

Prepared for: Arkansas State Medical Board

As of Date:1/23/2020

Practitioner Name: Parker, Willie James

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
ALABAMA	00031662	04/18/2012	12/31/2020	12/30/2019
CALIFORNIA	A-53102	05/25/1994		01/23/2020
DC	MD037446	06/30/2008	02/28/2013	12/26/2019
GEORGIA	71442	02/06/2014	10/31/2017	01/16/2020
HAWAII	MD-11733	10/11/2001	01/31/2010	08/09/2013
ILLINOIS	036131869	12/21/2012	07/31/2017	11/20/2019
IOWA	MD-28574	03/19/1992	10/01/1994	01/21/2020
MARYLAND	D69574	07/15/2009	09/30/2013	01/17/2020
MICHIGAN	4301087686	05/08/2006	01/31/2010	08/09/2013
MISSISSIPPI	22028	05/23/2012	06/30/2018	06/27/2018
NEW JERSEY	25MA09111500	05/18/2012	06/30/2013	11/01/2019
OHIO	35.063458	05/29/1992	04/01/2010	01/17/2020
PENNSYLVANIA	MD441490	11/09/2010	12/31/2016	01/10/2020
VIRGINIA	0101246274	08/13/2009	11/09/2012	01/15/2020

US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Schedule	Address	Expiration Date	Last Reported
	22N 33N 4 5	HUNTSVILLE,AL 35810	03/31/2022	01/10/2020

ENTERED
JAN 24 2020

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License Details - MD/DO/L

Alabama State Board of Medical Examiners

848 Washington Avenue
Montgomery, AL 36104

Personal Information

Licensee name:	Willie James Parker
Location:	Huntsville, Alabama

License Information

License type:	MD
License status:	Active
COQ status:	Issued
License number:	MD.31662
License description:	Full Unrestricted MD
Issue date:	04/18/2012
Expiration date:	12/31/2020
Practice Type	Gynecology
School Name:	University of Cincinnati College of Medicine
School Dates:	6/86-5/90
School Location:	Cincinnati
Public file:	No

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Alabama Controlled Substances Certificate

Status:	Active

License number:	ACSC.31662
Issue date:	01/01/2019
Expiration date:	12/31/2020
Schedules:	2, 2N, 3, 3N, 4, 5
Description:	Full Unrestricted ACSC
Restricted Comments:	None
Dispensing physician:	No

Collaborative Practice Agreement

No Collaborative Practice Agreements found.

Registration Agreement Information

No Registration Agreements found.

Printed from http://www.albme.org (http://www.albme.org /) Present Date 01/24/2020

* Please note that the Alabama Board of Medical Examiners and the Alabama Medical Licensure Commission have no authority over Nurse Practitioners or Midwives. For more information on these licenses, please visit the Alabama Board of Nursing, www.abn.alabama.gov

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JAN 24 2020

MEDICAL BOARD OF CALIFORNIA
LICENSING DETAILS FOR: A 53102

NAME: PARKER, WILLIE JAMES
LICENSE TYPE: PHYSICIAN AND SURGEON A
PRIMARY STATUS: LICENSE CANCELED
SCHOOL NAME: UNIVERSITY OF IOWA COLLEGE OF MEDICINE
GRADUATION YEAR: 1990
PREVIOUS NAMES: PARKER, WILLIE J
ADDRESS OF RECORD
635 LIBERTY POINTE DR
ANN ARBOR MI 48103
WASHTENAW COUNTY

ISSUANCE DATE
MAY 25, 1994
EXPIRATION DATE
N/A
CURRENT DATE / TIME
JANUARY 24, 2020
7:30:46 AM

PUBLIC RECORD ACTIONS

- ADMINISTRATIVE DISCIPLINARY ACTIONS (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
- COURT ORDER (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
- MISDEMEANOR CONVICTION (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
- PROBATIONARY LICENSE (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
- FELONY CONVICTION (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
- MALPRACTICE JUDGMENT (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
- HOSPITAL DISCIPLINARY ACTION (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
- LICENSE ISSUED WITH PUBLIC LETTER OF REPRIMAND (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
- ADMINISTRATIVE CITATION ISSUED (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
- ADMINISTRATIVE ACTION TAKEN BY OTHER STATE OR FEDERAL GOVERNMENT (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
- ARBITRATION AWARD (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)
- MALPRACTICE SETTLEMENTS (NO INFORMATION TO MEET THE CRITERIA FOR POSTING)

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PUBLIC DOCUMENTS

› DOCUMENTS (NO RECORDS)

SURVEY INFORMATION

THE FOLLOWING INFORMATION IS SELF-REPORTED BY THE LICENSEE AND HAS NOT BEEN VERIFIED BY THE BOARD.

ARE YOU RETIRED?	NOT IDENTIFIED
ACTIVITIES IN MEDICINE	PATIENT CARE - 10-19 HOURS TEACHING - 1-9 HOURS ADMINISTRATION - 1-9 HOURS OTHER - NONE RESEARCH - 10-19 HOURS
PATIENT CARE PRACTICE LOCATION	ZIP - 48103 COUNTY - NOT IDENTIFIED
PATIENT CARE SECONDARY PRACTICE LOCATION	NOT IDENTIFIED
TELEMEDICINE PRACTICE LOCATION	NOT IDENTIFIED
TELEMEDICINE SECONDARY PRACTICE LOCATION	NOT IDENTIFIED
CURRENT TRAINING STATUS	FELLOW
AREAS OF PRACTICE	OBSTETRICS AND GYNECOLOGY - PRIMARY
BOARD CERTIFICATIONS	NO BOARD CERTIFICATIONS IDENTIFIED
POSTGRADUATE TRAINING YEARS	6 YEARS
CULTURAL BACKGROUND	DECLINED TO DISCLOSE
FOREIGN LANGUAGE PROFICIENCY	DECLINED TO DISCLOSE
GENDER	MALE

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DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Search for a License

DC Health provides an online professional license search for your convenience. To begin a search select license type or enter key words or criteria in the fields below. Please enter details at least in Three Fields for accurate Results. As a search tip. Do not use dashes within social security numbers (SSNs).

"NOTE: Search results may take a little time, so please be patient. "

Click here to search for Health Facilities (https://app.hpla.doh.dc.gov/Weblookup/Search.aspx?facility=Y) rather than a person.

Search Again

License Number

RN30104

First Name

WILLIE

Last Name

JAMES

Profession

NURSING

Type

REGISTERED NURSE

Status

Expired

From State/Prov:

GA

Issue Date:

Expiration Date:

Temp. Issue Date:

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Discipline Information from 1996 to Present - Please click item(s) below to view public orders
Practitioner Profile - Unless otherwise indicated, this information has been self-reported and has not been verified by the Board of Medicine.

DISCLAIMER

The information contained in this web site is being made available as a public service by the District Of Columbia Department of Health. No posted information or material provided is intended to constitute legal or professional advice. The information contained in this web site was supplied from license applications and other sources such as schools and other states. The Department of Health makes no representations or warranties, either express or implied, as to the accuracy of any posted information and assumes no responsibility for any errors or omissions contained therein. Furthermore, no warranty, express or implied, is created by providing information through this web site and the presence of an individual licensee on the web site does not in any way constitute an endorsement by the Department of Health, the Health Regulation and Licensing Administration or any of its member boards. No one shall be entitled to claim detrimental reliance on any views or information, whether provided by or accessed through this web site, or to claim any duty on our part to update posted information or to protect the interests of those accessing this web site. In no event shall the Department of Health, the Health Regulation and Licensing Administration, its contractors, or its member boards or staff be held liable to you or anyone else for any decision made or action taken in reliance on such information or views. For more information regarding this web site or if you have any questions about information provided therein, please contact the Licensing Board of the Department of Health responsible for the license directly. The data is derived directly from DC Health - Health Regulation and Licensing Administration's Licensing Portal and is updated on a daily basis.

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JAN 24 2020

Details

Licensee Details

Please see below for details for the licensee you selected.

Name: Willie James Parker **Designation:** MD

Lic #: 71442 **Profession:** Physician **Subtype:** Full

Status: Lapsed **Issued:** 2/6/2014 **Expires:** 10/31/2017

Specialties

Specialty/Subspecialty	Certifying Board	Primary Specialty?
Obstetrics & Gynecology		Y

Disclaimer: Please note that many valid certifying specialty boards do not participate in the American Board of Medical Specialties (1-866-ASK-ABMS or www.abms.org) and actual verification of a physician's board certification is best accomplished by contacting the individual certifying specialty board.

Practice Address

Street Address: 235 West Wieuca Road
ATLANTA GA 30342

County: Fulton

Country: United States

Related Licenses

Relationship/Name	Dates	License Details

Public Documents

No public documents to display

Physician Profile

Disclaimer: This information has been provided by the physician and has not been verified by the Board. The Patient Right to Know Act requires physicians licensed to practice in the State of Georgia to provide certain information to the Board that is to be made available to the public. The Board relies upon information provided by the physicians to be true and correct, as required by statute. It is an act of unprofessional conduct for a licensee to provide erroneous information to the Board. The Board makes no warranty or guarantee concerning the accuracy or completeness of physician profiles.

For sections where there is no data, the Physician has not provided any information pertaining to that section.

Date of Profile Submission or Latest Update

Initial Licensure

Initial License State	Initial License Issue Date	Malpractice Coverage
IA	03/19/1992	

Practice Location History

City	State/Province	Country	From	To
Chicago	IL	US	01/05/2013	03/18/2014
Philadelphia	PA	US	01/01/2011	03/18/2014
Montgomery	AL	US	05/01/2012	03/18/2014
Washington	DC	US	06/01/2009	03/18/2014

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Details

Philadelphia	PA	US	01/01/2011	10/26/2015

Medicaid/Medicare

Currently Accepting Medicaid Patients?	Currently Accepting Medicare Patients?
N	N

Medical Education and Training

Education/Certifications

School Type	From	To	Graduated	School Name
Medical School			06/30/1990	UNIV OF IA ROY J & L CARVER COM, IOWA CITY, IA

Graduate Medical Education

Program Type/Specialty	GME/Hospital Name	From	To	City/State/Zip	Country	Graduated
OB-GYN Intership Residency	U of Cincinnati, College of Medici			Cincinnati OH 05229		
Preventative Medicine Residency	School of Public Health			Berkeley CA 94720		
Applied Epidemiology	CA Dept Hlth Svcs, Maternal Child H			Sacremento CA 95899		
Family Planning Fellowship	University of Michigan/Womens Hospi			Ann Arbor MI 48109		
	Family Planning Felllowship	07/05/2006	06/15/2008	Ann Arbor MI	US	
	Preventative Medicine Residenc	07/05/2000	06/15/2001	San Francisco CA	US	
	Applied Epidemiology	07/05/1998	06/15/2000	Sacremento CA	US	
	Residency in OB GYN	07/05/1990	06/15/1994	Cincinnati OH	US	

Current Hospital Privileges

Hospital Name	City/State/Zip
Washington Hospital Center	Washington DC 20010
U of Michican Health Systems	Ann Arbor MI 48109
Queen's Medical Center	Honolulu HI 96813
S/A Treatment Ctr/Kapiolani Medical	Honolulu HI 96826
Merced Community Medical Center	Merced CA 95340
Mercy Hospital	Merced CA 95340
Northwestern Memorial Hospital	

Final Disciplinary Action

Agency Name	Discipline Date	Violation Description	Action Type	Action Description

Hospital Privilege Revocations

Hospital Name	Discipline Date	Violation Description	Action Type	Action Description

Criminal Offenses

Date of Offense	Jurisdiction	Description of Offense

Medical Malpractice Judgment Arbitration Awards

List of medical malpractice court judgment and/or arbitration awards against this physician entered on or after April 11, 2001 that was in excess of $100,000 limited to the most recent 10 years.

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Details

Date Awarded	Amount Awarded

Disclaimer: Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

Medical Malpractice Settlement Amounts

A. Minimum four (4) settlements (regardless of amount).
B. Three (3) settlements with at least one (1) settlement over $100,000.00.
C. Any settlement in which at least one (1) payment is in excess of $300,000.00.

Settlement Date	Settlement Amount

Disclaimer: Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

List of physician's articles, journals, or publications limited to the most recent ten years

Date	Publication	Title

List of professional organizations, community service organization memberships or activities

Organization	Type	Description

Awards

Organization	Award/Honor

List of all languages excluding English used the by physician to communicate with patients and/or translation services available to their patients at the primary place of practice

Language
Spanish

List of Appointments to Medical School Faculties (Not hospital affiliations or privileges)

School	Position
Northwestern Medical School	

Physician's Comments

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JAN 24 2020

Professional & Vocational Licensing Search

Department of Commerce & Consumer Affairs

General Licensee

LICENSE STATUS NOT VALID UNABLE TO PRACTICE

License ID:	Active/Inactive:	Status	Expire Date:
MD-11733	--	TERMINATED; NEEDS TO REAPPLY	1/31/2010
Legal License Name:	**Trade/Professional Name:**	**Entity:**	**Original License Date:**
WILLIE PARKER	--	INDIVIDUAL	10/11/2001
Class Prefix:	**Special Privilege:**	**Restriction:**	**Education Code:**
--	--	--	--
Business Code	**Conditions & Limitations:**	**Business Address:**	
--	--		

License information on this site reflects information in the Professional and Vocational Licensing Division as of January 24, 2020; however, applications and forms are subject to standard processing time, and the information here does not reflect pending changes which are being reviewed. The site is updated daily, Monday through Friday, except holidays.

The State of Hawaii makes no guarantees as to the accuracy of the information accessed, the timeliness of the delivery of transactions, delivery to the correct party, preservation of the privacy and security of users and makes no warranties, including warranty of merchantability and fitness for a particular purpose. The DCCA/PVL web site receives the DCCA/PVL licensee information directly from the DCCA/PVL licensee database. The DCCA/PVL web site is considered a primary source for DCCA/PVL licensee information – it is the same licensee information the DCCA/PVL provides through other means and is true and correct to the best of our knowledge. User is advised that if the information obtained herein is to be reasonably relied upon, user should confirm the accuracy of such information with the provider thereof.

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Employees List

EMPLOYEES

Position	Position Status	Employee Name	Lic ID	Lic Status	Dual Rme	Effective

No data available in table

Showing 0 to 0 of 0 entries

Employers List

EMPLOYERS

Position	Employer Name	Lic ID	Lic Status	Effective

No data available in table

Showing 0 to 0 of 0 entries

Insurance / Bond

Insurance / Bond

Insurance Type	Effective	Term Date	Cancel Date	Policy #	Surety	Amount

No data available in table

Showing 0 to 0 of 0 entries

License Class

License Classes

Class Code	Class Type	Effective	Restricted	Status

No data available in table

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JAN 24 2020

Showing 0 to 0 of 0 entries

Back to Results | New Search (/pvlsearch)

Search RICO Complaints History (http://web.dcca.hawaii.gov/RICO)

Professional & Vocational Licensing

Department of Commerce & Consumer Affairs

Accessibility (http://portal.ehawaii.gov/accessibility.html) Contact (https://portal.ehawaii.gov/page/about-us/) Feedback (http://portal.ehawaii.gov/feedback.html?applicationId=5) Privacy Policy (http://portal.ehawaii.gov/privacy-policy.html) Terms of Use (http://portal.ehawaii.gov/terms-of-use.html)

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Illinois Department of Financial and Professional Regulation

Lookup Detail View

Contact

Contact Information

Name	City/State/Zip	DBA
WILLIE JAMES PARKER MD	Chicago, IL 60661	

License

License Information

License Number	Description	Status	First Effective Date	Effective Date	Expiration Date	Ever Disciplined
036131869	LICENSED PHYSICIAN AND SURGEON	NOT RENEWED	12/21/2012	06/24/2014	07/31/2017	N

Other Licenses

Other Licenses

License Number	Description	Status	First Effective Date	Effective Date	Expiration Date	Ever Disciplined
33*****57	LICENSED PHYSICIAN CONTROLLED SUBSTANCE (Schedules II III IV V)	NOT RENEWED	12/21/2012	06/24/2014	07/31/2017	N

Generated on: 1/24/2020 9:34:50 AM

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Physician - Permanent Details

Personal Information

First Name	Willie
Middle Name	James
Last Name	Parker
Other Names Used	Parker

License Information

License Type	Physician - Permanent
License Number	MD-28574
Status	Relinquished
Basis for Application	Endorsement
State of Principal License (if licensed via IMLC)	
Original Issue Date	03/19/1992
Expiration Date	10/01/1994
Renewal Date	
Relinquished Date	2015-07-01
Status at time of Relinquishment	Inactive
Public Charges and/or Public Discipline	No

Public Documents

Practice Information

	Not Specified
Primary Specialty	Not Specified
	Not Specified

Physician License Information Only: Please note that a physician's specialty information is self-reported and is not verified by this board.

NPI	

Location (Work Address - 1)

Address Type	Work
Business / Organization	
Bldg/House Number	1147
Street Prefix	
Street Name	TIOGA
Street Type	Court
Street Direction	
Unit Type	
Unit Number	
City	Merced
State	California
Zip Code	95340-697
Country	
Phone	

Education History

Medical or Acupuncture School	University Of Iowa College Of Medicine
Graduation Date	1990
Degree Received	MD

Back

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JAN 24 2020

Maryland Board of Physicians

Print Profile

Physician Profile Portal

License Number: D69574 Dr. Willie James Parker

License Type: Physician-Medical Doctor
Special License Category: N/A
License Status: **Expired**
Licensed Issued: 07/15/2009 License Expiration: 09/30/2013

Primary Practice Setting

Planned Parenthood Metro Washington
1108 16th Street NE
Washington, DC 20036

Public Address

1400 Spring Street
#450

Silver Spring, MD 20910

Education

UNIV OF IA COLL OF MED
Graduated: 1990

Medical Assistance and Malpractice Insurance

Accept Medicaid? No

Maintains Malpractice Insurance? Yes

Postgraduate Training Program

School	Concentration

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JAN 24 2020

► University of Cincinnati, Cincinnati, OH	Obstetrics & Gynecology
► University of Michigan, Ann Arbor, MI	Other

Specialty Board Certification

by ABMS (https://www.abms.org/), AOA (https://osteopathic.org/), Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada - as reported by licensee
Licensee has not reported Specialty Board Certification information for the profile site.

Self-Designated Practice Area

Licensee has not reported Self-Designated Practice Area information for the profile site.

Maryland Hospital Privilege Information (as reported by licensee)

Licensee has not reported Maryland Hospital Privilege information for the profile site.

Medical Licenses Held in Other States (as reported by licensee)

- ► California
- ► District of Columbia
- ► Hawaii
- ► Iowa
- ► Michigan
- ► Ohio

Active Supervisee - Delegation Agreement For Core Duties

Delegation Agreements have not been reported for the profile site.

Known Disciplinary Actions by any state medical board (within the past 10 years)

No Known Disciplinary Actions by any state medical board have been reported.

Download all Maryland Disciplinary Actions

All Orders are downloaded in .pdf format.
None.

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JAN 24 2020

Pending Charges

Please Read Description

All Charges are downloaded in .pdf format.

None.

Other Regulatory Board, Agency Public Actions, or Administrative Fines (including Maryland)

Please Read Description

No reported Other Regulatory Board, Agency Public Actions, or Administrative Fines for this licensee.

MALPRACTICE

Malpractice (Information to be taken into consideration when reviewing a Licensee's profile)

Please Read Malpractice Disclosure

▶ **Malpractice Judgments and Arbitration Awards** (within the past 10 years)

None Reported

▶ **Malpractice Settlements**

(If there are 3 or more settlements of $150,000 or greater within the past 5 years)

None Reported

Convictions for any crime involving moral turpitude

None reported by the courts.

Maryland Board of Physicians 4201 Patterson Avenue Baltimore, MD 21215
410.764.4777 | Toll Free 800.492.6836

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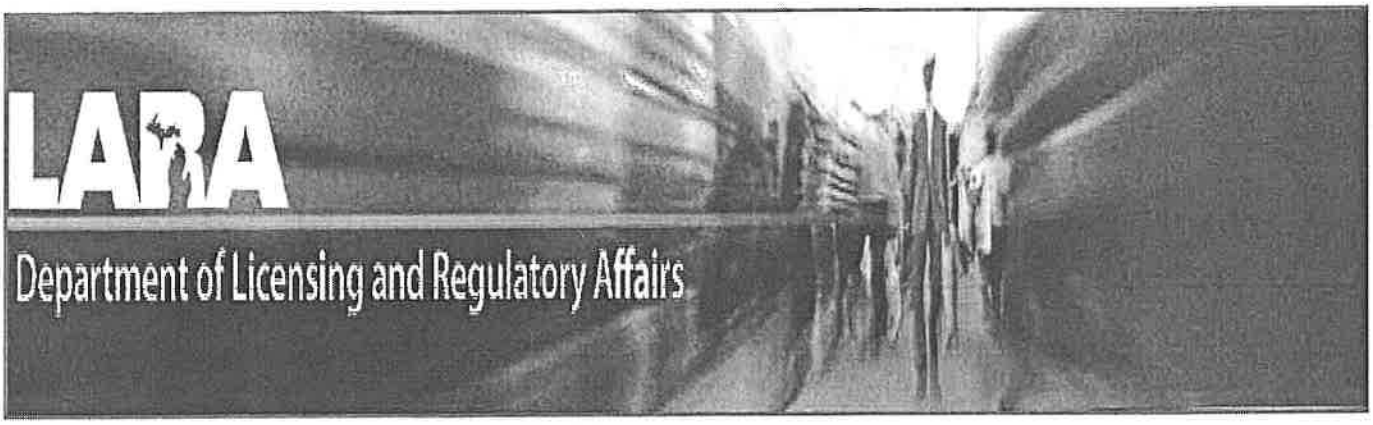
JAN 24 2020



Licensed Professional Information: Medical Doctor 4301087686

Licensee Detail

License Type:
Medical Doctor

License Number:
4301087686

Name:
Willie James Parker

License Issue Date:
05/08/2006

License Expiration Date:
01/31/2010

License Status:
Lapsed

County:
Washtenaw

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JAN 24 2020

CONTROLLED SUBSTANCE LIST

City: Ann Arbor

State or Province: Michigan

ZIP or Postal Code: 48109

CS Record Number: 5315026366

CS Status: Lapsed

CS Expiration Date: 01/31/2010

▸ <--- Click to view Public Documents

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JAN 24 2020

TELEPHONE: (601) 987-3079

FAX: (601) 987-4159

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

VERIFICATION OF MEDICAL LICENSURE

February 03, 2020

This is to certify that the records of the Mississippi State Board of Medical Licensure indicate the following information:

Physician Name: **WILLIE JAMES PARKER** Degree: **M.D.**

Primary Practice Location: **JACKSON WOMENS HEALTH ORG**
2903 N STATE ST
JACKSON, MS 39216

MD/DO School: **UNIVERSITY OF IOWA ROY J & L** Year of Graduation: **1990**

Specialty: **OBSTETRICS AND GYNECOLOGY (Not Primary Source Verified)**

License Number: **22028**
Issue Date: **May 23, 2012**
Expiration Date: **June 30, 2018**
Public Record: **NO**

Reinstated Date:
Date of Expiration Prior to Reinstatement:

This license information was last updated on: 02/03/2020

If public record is indicated, submit a request for records to the following email address: mboard@msbml.ms.gov.

Mississippi State Board Examination Scores:

Exam Date: June 12, 1990

Anatomy: 0.000
Chemistry: .000.
Physiology: 000.0
Histology and Bacteriology: 00.00
Pathology: 0.000
Materia Medica and Pharmacology: .000.
Hygiene: 000.0
Surgery: 00.00
Obstetrics and Gynecology: 0.000
Physical Diagnosis: .000.
Theory & Practice of Medicine: 00
Diseases of the Eye, Ear, Nose & Throat:

General Average:

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FEB 4 2020

TELEPHONE: (601) 987-3079

FAX: (601) 987-4159

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

VERIFICATION OF MEDICAL LICENSURE

February 03, 2020

Sincerely,

Kenneth Cleveland, MD
Executive Director

Cypress Ridge Building - 1867 Crane Ridge Drive, Suite 200-B Jackson, MS 39216
www.msbml.ms.gov

Paul R. R
Acting

License Information

Accurate as of January 24, 2020 9:37 AM

Return to Search Results

Name: WILLIE J PARKER

Address: Washington,DC

Profession/License Type: Medical Examiners,Medical Doctor

License No: 25MA09111500

License Status: Expired

Status Change Reason: Failure to Renew

Issue Date: 5/18/2012

Expiration Date: 6/30/2013

Documents

NO Board Actions. For more information contact New Jersey State Board of Medical Examiners (609)826-7100
No Public Documents

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JAN 24 2020

Ohio | eLicense Ohio Professional Licensure

License Look Up

1/24/2020 10:38 AM

Willie James Parker

Status	Inactive
Sub-Status	Expired
Board	Medical Board
License Type	Doctor of Medicine (MD)
License Number	35.063458
License Issue Date	05/29/1992
License Expiration Date	04/01/2010
License Effective Date	10/10/2007
City	Ann Arbor
State	MI
Country	
Board Action	No

Board Action Details
Current date & time: **1/24/2020 10:38 AM**

Disclaimer: The Joint Commission and NCQA consider on-line status information as fulfilling the primary source verification requirement for verification of licensure in compliance with their respective credentialing standards.

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JAN 24 2020

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

P. O. Box 2649

Harrisburg, PA 17105-2649

01/24/2020

License Information

WILLIE JAMES PARKER

Philadelphia, Pennsylvania 19106

Board/Commission:	State Board of Medicine	Status Effective Date:	01/04/2017
LicenseType:	Medical Physician and Surgeon	Issue Date:	11/09/2010
Specialty Type:		Expiration Date:	12/31/2016
License Number:	MD441490	Last Renewal:	01/15/2013
Status:	Expired		

Disciplinary Action Details

No disciplinary actions were found for this license.

This site is considered a primary source for verification of license credentials provided by the Pennsylvania Department of State.

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JAN 24 2020

Virginia Department of Health Professions License Lookup

Current as of 01/24/2020 10:40

License Information

License Number	0101246274
Occupation	Medicine & Surgery
Name	Willie J Parker
Address	Washington, DC 20017
Initial License Date	08/13/2009
Expire Date	11/09/2012
License Status	Expired
Additional Public Information*	No

Back to License Lookup Result

This serves as primary source verification of the credential issued by the Commonwealth of Virginia and meets the requirements of the Joint Commission.

* *"Yes" means that there is information the Department must make available to the public pursuant to §54.1-2400.2.G of the Code of Virginia; please note that this may also include proceedings in which a finding of "no violation" was made. For additional information click on the "Yes" link above. "No" means no documents are available.*

Back to License Lookup

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JAN 24 2020

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: 02/02/2020

VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED (NOT FOR HOSPITAL VERIFICATION)

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: Planned Parenthood Metro Washington
ATTN: Takina Wilson
Address Line 1: 1225 4th Street NE
Address Line 2:
City, State, ZIP Code: Washington, DC 20002

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
Parker, Willie James		

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
Parker	02/02/2020

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above): Planned Parenthood of Metropolitan Washington, DC

Employment Status: ☐ Current ☑ Inactive ☑ Leave of Absence ☐ Other _____

Date Employment Began	Date Employment Ended	
3/1/2009	12/1/2015	☑ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title: Provider - Medical Director

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed).

☑ Yes ☐ No ☐ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date
Takina Wilson		2/14/2020
Type or legibly print name: Takina Wilson		Position/Title: VP of Health Programs
Phone Number: 410591-4273	Fax Number:	E-mail Address: takina.wilson@ppmw.org

PLEASE RETURN THIS FORM DIRECTLY TO THE ARKANSAS STATE MEDICAL BOARD BY MAIL, FAX OR E-MAIL

(E-mail attachments must be in PDF format and sent to support@armedicalboard.org only)

RECEIVED

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FEB 25 2020

ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: 02/02/2020

VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED (NOT FOR HOSPITAL VERIFICATION)

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: Philadelphia Women's Center
ATTN: Clinic Administrator
Address Line 1: 777 Appletree Street
Address Line 2: 7th Floor
City, State, ZIP Code: Philadelphia, PA 19106

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
Parker, Willie James		

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
[signature]	02/02/2020

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above):

Employment Status: ☐ Current ☐ Inactive ☐ Leave of Absence ☒ Other INACTIVE INDEPENDENT CONTRACTOR

Date Employment Began	Date Employment Ended	
11/9/2010	02/29/2012	☐ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title: PHYSICIAN

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed).
☒ Yes ☐ No ☐ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date
[signature]		2/18/2020
Type or legibly print name: VALERIE BAKER		Position/Title: Center Compliance & Support Coordinator
Phone Number: (856) 356-4012	Fax Number: (856) 356-4038	E-mail Address: CRED@thewomenscenters.com

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ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: 02 / 01 / 2020

VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED (NOT FOR HOSPITAL VERIFICATION)

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: Family Planning Associates (Chicago)
ATTN: Diana Maracich, Administrator
Address Line 1: 659 W. Washington Blvd
Address Line 2:
City, State, ZIP Code: Chicago, IL 60661

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
Parker, Willie James		

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
[signature]	02/01/2020

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above)

Employment Status
☐ Current ☒ Inactive ☐ Leave of Absence ☐ Other

Date Employment Began	Date Employment Ended	☐ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
10/1/12	3/1/14	

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title: Medical Doctor/OBGYN

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed).
☒ Yes ☐ No ☐ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date
Diana Maracich		2/11/20
Type or legibly print name: Diana Maracich	Position/Title: COO	
Phone Number: 312-707-8988	Fax Number: 312-707-9223	E-mail Address: DMaracich@FPAChicago.com

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ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT
1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
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DATE OF REQUEST: 02/01/2020

VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED (NOT FOR HOSPITAL VERIFICATION)

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: Atlanta Women's Center
ATTN: Clinic Administrator
Address Line 1: 235 W Wieuca Road NE
Address Line 2:
City, State, ZIP Code: Atlanta, GA 30342

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
Parker, Willie James		

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
[signature]	02/01/2020

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above): AKA ATLANTA WOMEN'S MEDICAL CENTER

Employment Status: ☐ Current ☐ Inactive ☐ Leave of Absence ☒ Other INACTIVE INDEPENDENT CONTRACTOR

Date Employment Began	Date Employment Ended	☐ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
7/5/2013	6/17/2017	

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title: PHYSICIAN

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed).
☒ Yes ☐ No ☐ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date
[signature]		2/18/2020

Type or legibly print name		Position/Title
VALERIE BAKER		CENTER COMPLIANCE + SUPPORT COORDINATOR
Phone Number	**Fax Number**	**E-mail Address**
(856) 356-4012	(856) 356-4038	vred@thewomenscenters.com

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ARKANSAS STATE MEDICAL BOARD

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1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201
Phone: (501) 296-1802 Fax: (501) 296-1972
Emails with attachments must be sent in PDF format to support@armedicalboard.org

DATE OF REQUEST: 02/02/2020

VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED (NOT FOR HOSPITAL VERIFICATION)

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: West Alabama Womens Center
ATTN: Gloria Gray, Head Administrator
Address Line 1: 535 Jack Warner Parkway, Suite I
Address Line 2:
City, State, ZIP Code: Tuscaloosa, AL 35404

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
Willie James Parker		

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
Parker	02/02/2020

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above): as above

Employment Status: ☑ Current ☐ Inactive ☐ Leave of Absence ☐ Other

Date Employment Began	Date Employment Ended	☐ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
01/01/2014	Present	

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title: Independent

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed).

☑ Yes ☐ No ☐ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (Signature)		Signature Date
Gloria Gray		2/5/2020
Type or legibly print name: Gloria Gray	Position/Title: Director & Owner	
Phone Number: 205-394-4490	Fax Number: 205-554-0584	E-mail Address: docglo@aol.com

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DATE OF REQUEST: 02/01/2020

VERIFICATION OF EMPLOYMENT (Medical)

(for verification of employment that involved patient care) PART I AND PART II TO BE FILLED OUT BY THE APPLICANT–REQUIRED FOR VERIFICATION TO BE ACCEPTED (NOT FOR HOSPITAL VERIFICATION)

PART I – EMPLOYER NAME AND MAILING ADDRESS

Name of Employer: Alabama Women's Center
ATTN: Dalton Johnson
Address Line 1: 4831 Sparkman Dr NW
Address Line 2:
City, State, ZIP Code: Huntsville, AL 35810

PART II – PHYSICIAN INFORMATION

Full Name (Last, First, Middle)	Social Security Number	Date of Birth (mm/dd/yyyy)
Parker, Willie James		

AUTHORIZATION & RELEASE: I hereby authorize the entity named above, its staff or representative, to provide the Arkansas State Medical Board any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above-named entity for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Physician Signature	Date Signed (mm/dd/yyyy)
Parker	12/16/2019

PART III – VERIFICATION (TO BE COMPLETED BY EMPLOYER AUTHORIZED STAFF ONLY)

Please complete the information below (or your equivalent verification letter) and return directly to the Arkansas State Medical Board. Verifications sent to the physician cannot be accepted for verification purposes. Please provide exact dates if possible.

Name of Employer (if not correct above): Alabama Women's Center, LLC

Employment Status: ☑ Current ☐ Inactive ☐ Leave of Absence ☐ Other

Date Employment Began	Date Employment Ended	☐ If exact dates are not available, please check here. If currently employed, please write "Present" in the space for end date.
08/17/2016	Present	

Note: Breaks in employment should be listed as separate entries. If the Employee was there intermittently, a listing of each time period he/she was employed at your facility should be provided, either by copying this form for each time period, or by attaching a separate sheet detailing employment dates.

Current or Most Recent Position/Title: Attending Physican

To your knowledge, during the stated period of time, was the Employee in good standing? If No, please explain (attach additional sheets if needed).

☑ Yes ☐ No ☐ Unknown/Unable to comment

PART IV - VERIFIED BY

Verification provided by (signature)	Signature Date
	02/07/2020

Type or legibly print name	Position/Title
Dalton Johnson	Owner/Administrator

Phone Number	Fax Number	E-mail Address
(256)536-2231	(256)536-4634	Daltonsjohnson@gmail.com

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ARKANSAS STATE MEDICAL BOARD

LICENSURE DEPARTMENT

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201

Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org

Emails with attachments must be sent in PDF format to support@armedicalboard.org

ARKANSAS MEDICAL PRACTICES ACT and RULES AND REGULATIONS AFFIDAVIT

I AFFIRM THAT I HAVE READ THE ARKANSAS MEDICAL PRACTICES ACT, ARKANSAS CODE ANNOTATED SECTION 17-95-101, et. seq., AND THE RULES AND REGULATIONS OF THE ARKANSAS STATE MEDICAL BOARD.

Willie James Parker, MD, MPH

Physician's Full Name (First Middle Last, Suffix, Degree)

Physician's Signature (no rubber stamps)

12/16/19

Signature Date

THIS IS A REQUIREMENT FOR LICENSURE.
YOUR LICENSURE APPLICATION WILL NOT BE PROCESSED WITHOUT THIS COMPLETED FORM.

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ARKANSAS STATE MEDICAL BOARD

& CENTRALIZED CREDENTIALS VERIFICATION SERVICE

1401 W. Capitol Ave., Suite 340, Little Rock, AR 72201

Phone (501) 296-1802 Fax (501) 296-1972 www.armedicalboard.org

Emails with attachments must be sent in PDF format to support@armedicalboard.org

AUTHORIZATION AND RELEASE

To Whom It May Concern:

This document will authorize and direct any physicians with whom I have been associated; employees and medical staff members of any medical facility or hospital where I have been employed, on staff, or associated; any employees of any malpractice insurance carriers; any state medical licensing boards where I have been licensed or have applied for a license; any medical clinics where I have been employed or associated; and any medical schools where I have attended, to give to, copy for, or permit the personal inspection by employees or representatives of the Arkansas State Medical Board of any and all personnel records, disciplinary records, work records, military records, professional performance reviews, and/or evaluations of my performances.

I hereby release and discharge you and any other individuals or organizations referred to in this Authorization, and release you of any confidentiality requirements that might bind you, so that you may carry out the purposes of this document.

A copy of this document* may be provided to entities listed above, and this Authorization shall remain in effect for a period not to exceed two (2) years or until specifically revoked by me in writing.

Typed or Printed Name of Physician: Willie James Parker

Social Security Number: _____ _____

Signature of Physician: W Parker

Dark Blue or Black Ink Only - No Signature Stamps

Signature Date: 12/16/19

**** This document does not authorize the Arkansas State Medical Board to release information collected to third parties except as later authorized by the above physician and Arkansas State Law.***

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Chronology of Activities

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The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS in the medical professional application.

Start Date	End Date	Activity Type	Location
06/09/1986	05/04/1990	Medical Education	University of Iowa Carver College of Medicine Iowa City Iowa UNITED STATES
06/01/1990	07/01/1990	Vacation	University of Cincinnati Medical Center Cincinnati 45267 Ohio UNITED STATES
07/01/1990	06/30/1994	Postgraduate Training	University of Cincinnati Medical Center/College of Medicine Program Cincinnati Ohio UNITED STATES
07/01/1994	06/01/1997	Work	Merced Communit Medical Center 333 Mercy Ave Merced, California UNITED STATES
07/01/1997	06/05/1998	PGT/Education	Harvard School of Public Health Boston Massachusetts UNITED STATES
07/01/1998	06/01/2000	Work	CDC Epidemic Intelligence Service Ca Dept of Hlth Services, Maternal Child Health Br 1615 Capitol Ave, 5th Floor Sacramento, California UNITED STATES
07/01/2000	06/30/2001	Postgraduate Training	University of California (San Francisco)/University of California School of Publ San Francisco California UNITED STATES
07/01/2001	01/01/2002	Work	California Dept. Of Health Services PO Box 997377 MS 0500 Sacramento, California UNITED STATES
01/01/2002	05/30/2006	Work	Queen's Medical Center 1301 Punchbowl Street Honolulu, Hawaii UNITED STATES
06/01/2006	07/01/2006	Vacation	Queens Medical Center Honolulu Hawaii UNITED STATES
07/01/2006	06/30/2008	Postgraduate Training	University of Michigan Health System Ann Arbor Michigan UNITED STATES
07/01/2008	05/30/2009	Work	Washington Hospital Center 110 Irving Street, NW DC, Washington UNITED STATES
06/01/2009	07/01/2011	Work	Planned Parenthood Metropolitan Washington, DC 1225 4th Street NE Washington, District Of Columbia UNITED STATES

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Chronology of Activities

07/01/2010	12/30/2015	Work	Philadelphia Womens Center 777 Appletree Street 7th Floor Philadelphia, Pennsylvania UNITED STATES
01/01/2012	12/31/2014	Work	Family Planning Associates 659 W. Washington Blvd Chicago, Illinois UNITED STATES
06/01/2012	04/01/2016	Work	Jackson Women's Health Organization 2903 North State Street Jackson, Mississippi UNITED STATES
07/01/2012	05/01/2016	Work	Reproductive Health Services 811 South Perry Street Montgomery, Alabama UNITED STATES
07/01/2013	08/30/2017	Work	Atlanta Womens Center 235 W Wieuca Rd NE Atlanta, Georgia UNITED STATES
01/01/2014		Work	West Alabama Women's Center 535 Jack Warner Parkway Suite I Tuscaloosa, Alabama UNITED STATES
06/01/2016		Work	Alabama Women's Center 4831 Sparkman Dr NW Huntsville, Alabama UNITED STATES

End of Chronology of Activities report for: Parker, Willie James

WILLIE JAMES PARKER, MD, MPH, MSc

EDUCATION

9/2006 - 5/2008 **University of Michigan School of Medicine, Ann Arbor, Michigan.**
Masters of Health and Health Care Research. Degree awarded December, 2008.

7/1997 - 6/1998 **Harvard School of Public Health, Boston, Massachusetts.**
Master's of Public Health. Degree awarded June, 1998

6/1986 - 5/1990 **University of Iowa College of Medicine, Iowa City, Iowa.**
Doctor of Medicine. May, 1990.

9/1981 - 5/1986 **Berea College, Berea, Kentucky.**
Bachelor of Arts. May, 1986. Major-Biology.

6/1984 - 8/1984 **Harvard University, Cambridge, Massachusetts.**
No degree. Summer, 1984.

POST DOCTORAL TRAINING

7/2006 - 6/2008 **Family Planning Fellowship, The University of Michigan, Ann Arbor MI**, Department of Obstetrics & Gynecology.

7/2000 - 6/2001 **Preventive Medicine Residency. University of California, San Francisco- University of California, Berkeley Joint Program, San Francisco, CA.**
Residency in Preventive Medicine. Diplomate.

7/1998 - 6/2000 **Centers for Disease Control: Epidemic Intelligence Service, Atlanta, Georgia.**
Placement Site: CA Department of Health Services, Maternal Child Health Branch, Sacramento CA. EIS Officer. Conducted acute disease outbreak investigation, analytic research, and provided technical assistance to local and regional health departments.

7/1990 - 6/1994 **The University of Cincinnati College of Medicine, Cincinnati, Ohio.**
Residency in Obstetrics and Gynecology.

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ACADEMIC APPOINTMENTS

3/2013 - 1/2017	**Northwestern University Feinberg School of Medicine, Chicago, Illinois** Clinical Instructor, Department of Obstetrics and Gynecology.
8/2008 - 5/2009	**Washington Hospital Center Residency in Obstetrics & Gynecology.** Director, Division of Family Planning and Preventive Services.
7/2006 - 6/2008	**The University of Michigan, Ann Arbor MI.** Clinical Lecturer, Department of Obstetrics & Gynecology.
1/2002 - 5/2006	**John A Burns School of Medicine, University of Hawaii, Honolulu, Hawaii.** Assistant Professor, Department of Obstetrics and Gynecology.
4/1999 - 12/2001	**University of California-Davis Medical Center Obstetrics and Gynecology Residency Program, Sacramento, California..** Volunteer Faculty appointment.

ACADEMIC ADMINISTRATIVE APPOINTMENTS

1/2003 - 4/2006	**Queen's Medical Center, Honolulu, Hawaii** OB-Gyn Peer Review Committee.

CLINICAL/HOSPITAL APPOINTMENTS

3/2013 - present	**Northwestern University Feinberg School of Medicine, Chicago, Illinois** Clinical Instructor, Department of Obstetrics and Gynecology.
8/2008 - 3/2013	**Washington Hospital Center Residency in Obstetrics & Gynecology, Washington, DC.** Division of Family Planning and Preventive Services.
7/2006 - 6/2008	**University of Michigan Health Systems, Ann Arbor Michigan.** Clinical Instructor, Department of Obstetrics and Gynecology.
1/2002 - 4/2006	**Queen's Medical Center, Honolulu, Hawaii** Attending Physician, Queen Emma Clinics.
6/2003 - 6/2006	**Sex Abuse Treatment Center, Kapiolani Medical Center for Women and Children, Honolulu, Hawaii.** Examiner for sexual assault in the community as part of a team response. Performed injury assessment, disease and pregnancy prevention screening and treatment, forensic examination, and expert testimony.

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7/1994 - 6/1997 **Merced Community Medical Center, Merced California**
Staff Physician.

7/1994 - 6/1997 **Mercy Hospital, Merced, California**
Staff Physician.

SCIENTIFIC ACTIVITIES

None

GRANT SUPPORT

None

CERTIFICATIONS AND LICENSURE

State Licenses

California, May 1994	#A053102	Expired	10/31/2009
Hawaii, October 2001	#11733	Expired	01/31/2010
Ohio, April 1991	# 35063458	Expired	04/1/2010
Michigan, May 2006	#4301087686	Expired	01/31/2010
Wash. DC June, 2008	#MD03746	Expired	02/28/2013
Maryland, July, 2009	#D0069574	Expired	09/30/2013
Virginia, August 2009	#0101246274	Expired	10/31/2012
Pennsylvania, Nov, 2010	**#MD441490**	**Expired**	**12/31/2016**
Illinois, December 2012	**#036131869**	**Expires**	**07/31/2018**
Mississippi, May, 2012	**#22028**	**Expires**	**06/30/2017**
Alabama, April, 2012	**#31662**	**Expires**	**12/31/2017**
New Jersey, May, 2012	#25MA091115000	Expired	06/30/2013
Iowa, March, 1992	#28574	Expired	10/01/1994
Georgia, February, 2014	**# 071442**	**Expires**	**10/31/2017**

American Board of Obstetrics and Gynecology

Certification: 11/15/1996	# 940869	Expires	12/31/2017
Pediatric Advanced Life Support		Expires	10/31/2014
Basic Life Support.		Expires	10/31/2016
Advanced Cardiac Life Support		Expires	10/31/2018
DEA # BP3174264 (Alabama)		Expires	03/30/2018

MILITARY SERVICE

None.

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EMPLOYMENT

7/2016- present **Alabama Women's Center, Tuscaloosa, AL**
Independent Contractor. Duties include family planning services and provision of abortion care.

1/2015- present **West Alabama Women's Center, Tuscaloosa, AL**
Medical Director. Responsible for clinical and laboratory services for clinic. Duties include family planning services and provision of abortion care.

07/2014 - present **Atlanta Women's Medical Center, Inc., Atlanta, GA**
Independent Contractor. Duties include family planning services and provision of abortion care.

1/2013 - present **Family Planning Associates, Chicago, IL.**
Associate Medical Director. Responsible for clinical and laboratory services for three clinics in metropolitan Chicago. Duties include family planning services, resident and fellowship education, and provision of abortion care.

6/ 2012 - present **Jackson Women's Health Corporation, Jackson, MS.**
Independent Contractor. Duties include family planning services and provision of abortion care.

5/ 2012 - present **Reproductive Health Services, Montgomery, AL.**
Independent Contractor. Duties include family planning services and provision of abortion care.

1/ 2011 - present **Philadelphia Women's Center, Philadelphia, PA.**
Independent Contractor. Duties include family planning services and provision of abortion care.

6/ 2009 – 01/2013 **Planned Parenthood, Metropolitan Washington, Washington DC.**
Independent Contractor. Duties include family planning services and provision of abortion care.

6/ 2009 - 7/2011 **Planned Parenthood, Metropolitan Washington, Washington DC.**
Medical Director. Responsible for clinical and laboratory services for this Affiliate operating five clinics in Maryland, Virginia, and the District of Columbia. Duties include family planning services, resident education, and provision of abortion care.

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8/ 2008 - 5/2009 **Washington Hospital Center Residency in Obstetrics & Gynecology.** Director, Division of Family Planning and Preventive Services. Established family planning services, resident education, and conduct abortion care in the District of Columbia.

7/ 2006 - 6/2008 **University of Michigan Health Systems, Ann Arbor Michigan.** Clinical Instructor, Department of Obstetrics and Gynecology. General obstetrics and gynecology, resident education, and family planning/abortion care .

1/ 2002 - 5/2006 **John A Burns School of Medicine, University of Hawaii, Honolulu, Hawaii.** Assistant Professor, Department of Obstetrics and Gynecology. General obstetrics and gynecology, resident education, and family planning/abortion care .

5/ 2001 - 11/ 2001 **California Department of Health Services, Sacramento, California.** Chief, Policy and Programs, Maternal Child Health Branch. Coordinated statewide identification and monitoring of resources associated with care of women and children; supervised a staff of 30 and accountable for a multimillion dollar budget; wrote reports as required by legislature.

8/1999 - 8/2000 **Sacramento Birthing Project: Sacramento CA.** Volunteer Clinician. Provided ambulatory, prenatal clinical services to high-risk/at-risk mothers in an urban setting with culturally sensitive interventions.

7/1994 - 6/1997 **National Health Service, Merced, California.** Placement Site: Golden Valley Health Centers Inc.. Staff Obstetrician and Gynecologist. Practiced full range of general obstetrics and gynecology in a medically under-served area. Range of responsibilities clinically included limited "high risk" obstetrics and basic infertility evaluation and treatment.

8/1995 - 6/1997 **UC-Davis Affiliated Family Practice Residency Program, Merced, California.** Independent contractor. Taught obstetrics and gynecology to Family Medicine residents. Provided consultation, staffed gynecology outpatient clinics, provided intrapartum consultation and management.

8/1992 - 6/1994 **Our Ladies of Mercy Hospital, Anderson, Ohio.** House Physician. Duties involved assessment of obstetric patients, surgical assisting, and fetal monitoring interpretation.

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6/1992 - 6/1994 **The Jewish Hospital, Cincinnati, Ohio.** Duties identical to duties at Mercy Hospital, Anderson.

HONORS

Dr. Felicia Stewart Award for Reproductive Health Leadership
American Public Health Association, Denver, CO. October, 2015

Dr. David Gunn Lifetime Achievement Award.
Abortion Care Network. St. Petersburg, FL. January, 2016.

Helen Rodriguez Trias Award for Social Justice
American Public Health Association, Chicago, IL. November, 2015.

Margaret Sanger Award
Planned Parenthood Federation of America. January, 2015.

Moody-Patterson Award for Leadership in Reproductive Justice.
Religious Coalition for Reproductive Choice, Washington, DC. January, 2013.

George R. Tiller, MD, Abortion Provider Award.
Physicians for Reproductive Health, NY, NY. June, 2013.

Citizen of the Year. Men's March Against Violence.
Men's March Against Violence, Honolulu, Hawaii. October, 2004.

Berea College Outstanding Young Alumnus Award.
Berea College Alumni Association. November, 2001.

NAACP Freedom Fund Banquet, Community Service Award,
NAACP, Merced County, CA. October, 1996.

National Health Service Corps Director's Award.
U.S. Department of Health and Human Services, San Francisco, CA. October, 1995.

V. Bradley Roberts Award, The Christ Hospital, Cincinnati, Ohio.
University of Cincinnati OB- GYN Residency Program. June, 1994.

University of Cincinnati Esprit de Corps Award.
University of Cincinnati OB- GYN Residency Program. June, 1994.

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University of Cincinnati Resident Research Day, Third Place.
University of Cincinnati OB- GYN Residency Program. June, 1994.

Executive Chief Resident, Department of OB-GYN.
University of Cincinnati OB- GYN Residency Program. 1993-1994.

J. Bates Henderson Medicine Scholarship.
Berea College. November, 1986.

E.R. Brann Good Citizenship Award and the Homer E. Williams Award for Promoting Interracial Understanding.
Berea College, 1984.

TEACHING ACTIVITIES

Clinical Instructor, Northwestern School of Medicine.
OB-Gyn Dept. 2006-2008

Assistant Professor, Medstar/Washington Hospital Center Obstetrics and Gynecology Residency Program. 2008-2013

Clinical Instructor, University of Michigan School of Medicine, OB-Gyn Dept. 2006-2008

Faculty Advisor, Fourth Year Resident Class University of Hawaii Residency Training Program. 2004-2006.

Presenter, Merced County African-American Educators Association's Booker T. Washington Revisited Minority Student Career Fair. September, 1994, 1995, 1998.

Consultant, Merced County School Board Sex Education Curriculum Review Committee. 12/1995

EXTRAMURAL INVITED PRESENTATIONS

"Domestic Violence: When Love Hurts. Implications for Family Planning" OB-Gyn Grand Rounds.
Georgetown/Washington Hospital Center,Washington, DC, September 13, 2012

"Becoming Marginal Individuals: Challenges of the Modern Abortion Provider" Presentation, Medical Students For Choice Regional Conference. Philadelphia PA April 27, 2012

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"Reproductive Justice". Panelist, National Abortion Federation Annual Meeting, Vancouver, British Columbia April, 2012

"Abortion and/or Religion: Whats your Connnector?". Physicians for Reproductive Choice and Health Leadership Training Academy. New York, NY, March 1, 2012.

"Miscarriage Management"
Grand Rounds, Aurora Health Systems, Milwaukee, WI, November 1, 2011

"Black Infant Mortality: The Role that Men Can/Don't Play". Project Blossom Conference: Place, Race, and Poverty. Nashville TN, September 30, 2011.

Commission on Paternal Involvement in Pregancy Outcomes. Panelist, Capital Hill briefing, U.S. House of Representatives. Washington, DC, May 20, 2011.

"Reclaiming the Moral Center". Panelist, National Abortion Federation Annual Meeting, Chicago IL, April, 2011.

"Reproductive Justice: Becoming the Change That You Wish To See". Presentation, American Medical Student Association National Conference, March 13, 2011.

"Abortion and/or Religion: Whats your Connnector?". Physicians for Reproductive Choice and Health Leadership Training Academy. New York, NY, February 28, 2011.

Champions of Choice Awards Luncheon, Planned Parenthood Metropolitan Washington. Keynote Speaker. Washington, DC, October 20, 2010.

"Essentials of First Trimester Abortion"
Grand Rounds, Aurora Health Systems, Milwaukee, WI March 25, 2010

"It Takes Two to Tango: Defining the Role of the Expectant Father". Plenary Speaker, National Healthy Association 11th Annual Spring Conference, Washington, DC. March 14-17, 2010

"Challenges for Abortion Providers of Color: When You Are Not The Provider She Wanted"
UCSF Psychosocial Workshop for Abortion Providers, March 13, 2010

"First Trimester Abortion". OB-Gyn Grand Rounds. Meharry Medical College, Nashville TN January 13, 2010.

"Male Contraception: If You Build It, Will They Come"

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Family Planning Faculty Development Course, Kwame Nkrumah University of Science and Technology Kumasi, Ghana. January19, 2010

"Disparities in Reproductive Health"
Racial and Ethnic Health Disparities Course, George Washington School of Public Health.
September 22, 2009

"Long Acting Reversible Contraception (LARC): Dispelling the Myths, Embracing the Evidence."
National Medical Association Annual Conference. Las Vegas, Nevada. July 27, 2009

"Domestic Violence: When Love Hurts"
Lunch Lecture, Planned Parenthood, Metropolitan Washington, July 7, 2009

"Office Based Management of Early Pregnancy Loss"
OB-Gyn Grand Rounds, George Washington University , Washington, DC. April 29, 2009

"Essentials of Second Trimester Abortion"
Resident Lecture, Washington Hospital Center, March 13, 2009

"Emergency Contraception"
Family Planning Faculty Development Course, University of Ghana , Accra, Ghana. January 22, 2009

"Male Contraception: If you Build It, Will They Come?"
OB-Gyn Grand Rounds, Washington Hospital Center. January 17, 2009.

"Surgical Abortion"
Medical Students for Choice Clinical Seminar, Wayne State School of Medicine

"Male Contraception: If you Build It, Will They Come?"
OB-Gyn Grand Rounds, University of Michigan , Ann Arbor, MI. November 29, 2007

"Unmet Contraceptive Need in U.S. Men Ages 15-44".
Poster presentation, Association of Reproductive Health Professionals Annual Meeting, Minneapolis, MN. September 26, 2007

"Early Pregnancy Failure"
OB-Gyn Grand Rounds, Queens Medical Center
Honolulu, Hawaii. August 7, 2007

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"MVA for Early Pregnancy Loss"
OB-Gyn Grand Rounds, Kapiolani Medical Center for Women and Children
Honolulu, Hawaii. August 9, 2007

"Contraceptive Counseling, Reproductive Freedom, and the Impact of Family Planning in the African American Community"
National Medical Association Annual Conference
Honolulu, Hawaii. August 6, 2007

"Unmet Contraceptive Need in U.S. Men Ages 15-44".
Family Planning Fellowship Annual Meeting, San Diego, CA. May 4, 2007

"Domestic Violence in Pregnancy"
Healthy Mothers Healthy Babies Coalition of Hawaii Annual Conference: New Frontiers in Maternal and Infant Health Care: Ethics, Outcomes and Practices in the 21st Century".
Honolulu, Hawaii. June 8, 2006

" Sound The Alarm: Non-medical Health Hazards for Women".1. Not to People Like Us: Domestic Violence in Upscale Relationships/Marriage, 2. The Implications of the Reversal of Roe vs. Wade For You, Today's Black Woman 3. The New Face of HIV/AIDS: The Move From Gay White Men to Heterosexual Black and Brown Women: You!"
Pfizer Women's Health Lecture, Spelman College, Atlanta Georgia. April 3, 2006

"Physician Response to Substance Use in Pregnancy: When Women Behave Badly"
State-wide Grand Rounds Tour to Maternity Hospitals Throughout Hawaii, March-December, 2005. Nine Hospitals throughout the Hawaiian Islands. Sponsored by March of Dimes, Hawaii.

"Domestic Violence: Evidence for Screening."
OB-Gyn Grand Rounds, University of Cincinnati Residency Program.
Honolulu, Hawaii. June 1, 2005

"Lesbian Health Care"
OB-Gyn Grand Rounds, Queens Medical Center
Honolulu, Hawaii. June 28, 2004

"Lesbian Health Care: An Update."
OB-Gyn Grand Rounds, Kapiolani Medical Center for Women and Children
Honolulu, Hawaii. June 9, 2004

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"Emergency Contraception Update"
OB-Gyn Grand Rounds, Queens Medical Center
Honolulu, Hawaii. January 5, 2004

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"Contemporary Use of the Pessary: An Update."
OB-Gyn Grand Rounds, Kapiolani Medical Center for Women and Children
Honolulu, Hawaii. September 30, 2002

"Domestic Violence: Trouble in Paradise."
OB-Gyn Grand Rounds, Queens Medical Center
Honolulu, Hawaii. March 5, 2003

"Contemporary Use of the Pessary: An Update."
OB-Gyn Grand Rounds, Queens Medical Center
Honolulu, Hawaii. September 30, 2002

"Maternal Mortality: Miles to Go Before We Sleep...."
OB-Gyn Grand Rounds, Queens Medical Center
Honolulu Hawaii. March 11, 2002

"Public Health Response to Needle Re-Use by a Phlebotomist, Northern California 1999" oral presentation. 2000 Centers for Disease Control Epidemic Intelligence Service Conference. Atlanta, GA. April 15, 2000

"State-Specific Changes in Singleton Pre-term Births Among Black and White Women-United States--1990 and 1997" oral presentation. 2000 Centers for Disease Control Epidemic Intelligence Service Conference. Atlanta, GA. April 11, 2000

"Cesarean Section Related Maternal Mortality: California, 1995-1997"
Oral presentation, 1999 American Public Health Association Conference.
Chicago, IL. November 7, 1999

"Perceptions of Weight Gain during Pregnancy by Women: California Women's Health Survey 1998"
Poster presentation. 1999 National Substance Abuse and Mental Health Conference for Women, Department of Health and Human Services, Los Angeles, CA. June 27-30, 1999.

"Cesarean Section Related Maternal Mortality: California, 1995-1997"
Poster presentation. 1999 California Maternal and Child Health Conference: *Capitolizing Our Resources*, Sacramento, California. May 24-25, 1999.
Poster presentation, 1 CDC/HRSA Maternal-Child/Infant Health Epidemiology Workshop, Atlanta, GA. December 8-9, 1999.

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"Maternal Mortality Surveillance: Improved Detection Using Hospital Discharge Data-Death Certificate Data Linkage, California, 1995-97"

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Oral presentation. 1999 California Maternal and Child Health Conference Sacramento, California. May 24-25, 1999.

"Pregnancy-Related Morbidity in African-American Women: California, 1997"
Oral presentation. California Department Of Health Services Black Infant Health Program Provider Training Meeting, Sacramento, CA. May 23, 1999.

"Trends in Perinatal Outcomes: California 1990-97"
Oral presentation. CA Department of Health Services, Regional Training for the California Comprehensive Perinatal Services Program. Santa Barbara, CA. February 10-11, 1999.

"Maternal Mortality Surveillance in California- Proposal of a Surveillance System based on Hospital Discharge Data"
Oral Presentation. Epidemiology Grand Rounds, Centers for Disease Control, Atlanta GA. October 27, 1998.

"Needs Assessment for a Middle School-based Health Center: Assessment of Inner-City Boston Public School"
Oral presentation. Family and Community Health Practicum, Harvard University School of Public Health, May 5, 1998.

"Medical Management of Ectopic Pregnancy"
Lecture. UC-Davis Merced Family Practice Residents, December 12, 1996.

"Pelvic Inflammatory Disease"
Lecture. UC-Davis Merced Family Practice Residents, December 26, 1995.

"Adolescent Pregnancy"
Oral presentation. National Health Service New Provider Orientation Conference, Region IX, San Francisco, CA, October 13, 1995.

"Amniocentesis"
Lecture. Merced Community Medical Center Obstetric Labor and Nursing Seminar, August 11, 1995.

"Preterm Labor- Current Thought"
Lecture. Merced Community Medical Center Obstetric CME Program, February 5, 1995.

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COMMITTEE AND ADMINISTRATIVE SERVICE

Physicians for Reproductive Choice and Health, New York, NY. November, 2007- Present.
Board of Directors.

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Teen Alliance for Prepared Parenting, Washington Hospital Center, Washington, DC. 2009-Present. Community Advisory Board.

Religious Coalition for Reproductive Choice, Washington DC. May 2012 to present Board of Directors
Berea College Alumni Executive Counsel, Berea, Kentucky
1997-2002. President of the Counsel, 2001-2002.

Domestic Violence Clearing House Hotline and Legal Services, Honolulu, HI. September, 2002-May, 2006. Board of Directors.

Health Mothers, Healthy Babies- Honolulu, HI. March, 2004 –May 2006.
Board of Directors. Nationally-affiliated non-profit community agency devoted to advocacy, education, and policy development for perinatal health in the state of Hawaii.

Planned Parenthood Federation of America- Hawaii Affiliate. 1/2005-5/2006
Board of Directors

American Public Health Association, 1998-2006.

American College of Obstetrics and Gynecology, 1990-1996, 2006-present.

National Medical Association, 7/1995-present.

BIBLIOGRAPHY

Peer-Reviewed Publications

Contraception 86 (2012) 1–3 Joffe C, Parker WJ
Editorial. Race, reproductive politics and reproductive health care in the contemporary United States

Contraception 83 (2011) 289–290 Shih G, Turok DK, Parker WJ
Editorial. Reversing the United States sterilization paradox by increasing vasectomy utilization

Contraception 2011, Apr ;83 (4):310-5 21397087 Grace Shih, David K Turok, Willie J Parker
Vasectomy: the other (better) form of sterilization.

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Hawaii Medical Journal November 2009, Volume 68, No. 10, ISSN: 0017-8594. Domestic Violence Screening In Pregnancy
MY Bunn MD, MPH; NA Higa MD; WJ Parker MD, MPH; B Kaneshiro MD, MPH

Non-Peer-Reviewed Publications

Public Health Reports, 2003; 118:324-35.*Black*-White infant mortality disparity in the United States: a societal litmus test: commentary on"A partnership to reduce African American infant mortality in Genesee County, Michigan."

Morbidity and Mortality Weekly Report, September 22, 2000/ 49(37); 837.
State-Specific Changes in Singleton Pre-term Births Among Black and White Women-United States--1990 and 1997.

Book Chapters

"Breast Discharge/Galactorrhea", and "Cervical Lesions - Polyp, Condyloma, Nabothian Cyst, Other"
The 5-Minute OB/GYN Clinical Consult, Paula J. Hillard, MD, editor, 2007

Book
AUTHOR
Life's Work: A Moral Argument for Choice. Atria Books, April 4, 2017

Abstracts:

1999 American Public Health Association Conference. Chicago, IL.
"Cesarean Section Related Maternal Mortality: California, 1995-1997"

2000 CDC Epidemic Intelligence Service Conference. Atlanta, GA
"State-Specific Changes in Singleton Pre-term Births Among Black and White Women-United States--1990 and 1997"

2000 CDC Epidemic Intelligence Service Conference. Atlanta, GA
"Public Health Response to Needle Re-Use by a Phlebotomist, Northern California 1999"wjpCV

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FEDERATION CREDENTIALS VERIFICATION SERVICE

2019 DEC 13 2:17

Medical Professional Information Profile

This report provides credentialing information for:

Name: **Parker, Willie James**

FID#: **206149312**

Recipient: **AR - Arkansas State Medical Board**

Delivery Date: **12/11/2019**

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing Institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the Institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

This FCVS Medical Professional Information Profile ("Profile") is compiled and provided by the Federation of State Medical Boards of the United States, Inc. (Federation) as a reference source for, and only for, its member boards and other entities authorized by the Federation. The Profile embodies and contains confidential business information because the information, and the format and presentation of that information, comprise trade secrets of the Federation and because the Profile's disclosure would harm the Federation by providing others with an unfair business advantage in competing with the Federation's FCVS services. Further, the form of the Profile and the contents of this Profile, including the compilation of information in this Profile, are the Federation's copyrighted works and proprietary, confidential information and are subject to the protections of United States laws governing copyright, trademark and trade secrets, as well as various state laws protecting the Federation's trade secrets and other intellectual property rights. This Profile and its contents may not be (1) copied, reformatted, modified, published or displayed publicly or (2) used, disclosed, distributed, shared or sold, in whole or part, for any purpose, including use to establish any database or files as a compendium or otherwise, all of which is strictly prohibited without the express written consent of the Federation's CEO.

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FEDERATION OF STATE MEDICAL BOARDS

400 FULLER WISER ROAD | EULESS, TX 76039 | TEL (817) 868 - 5000 | FAX (817) 868 - 5099

FCVS | FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to me being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

Notary:
Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

I hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

HANNA KOBYLINSKA ELECTRONIC NOTARY PUBLIC REG # 7809096 EXPIRES 7/31/2022 COMMONWEALTH OF VIRGINIA

Applicant's Signature (must be signed in the presence of a notary)

Parker

Applicant's Printed Last Name

Willie J

Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

12/08/2019

Date of Signature (must correspond to date of notarization)

State of Virginia, County of James City

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 08 day of December, 2019.

Notary Public Signature: Hanna Kobylinska

My Notary Commission Expires: 07/31/2022

Please complete and mail this original document to the Federation of State Medical Boards at:

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 |

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NotaryCam DocID:5dedb88313f19a52685e4158

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Identity

Biographic Information

Medical professional Name(s): **Parker, Willie James**

Place of Birth: abama, UNITED STATES

Contact Information

Credentials Analysis Information for Identity

There is no Omission/Discrepancy/Miscellaneous information identified.

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

Applicant Full Legal Name: Parker (Last) Willie (First) James (Middle)

FCVS ID Number: 206149312

Notary – Please complete the section below:

State of Virginia County of James City

I certify that on the date set forth below, the individual named above, did appear personally before me and presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Passport). I further certify that I did identify this applicant by comparing his/her physical appearance with the photograph on a Government issued photo identification presented by the applicant.

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 08, of (Month) December, (Year) 2019.

Notary Public Signature: Hanna Kobylinska

Commission Expiration Date* (Month) 07 / (Day) 31 / (Year) 2022

*** The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided.**

Notary Stamp Here

HANNA KOBYLINSKA
ELECTRONIC NOTARY PUBLIC
REG # 7806090
EXPIRES 7/31/2022
COMMONWEALTH OF VIRGINIA

Please complete and mail this original document and a photocopy of the birth certificate or passport presented to the Notary to:

Federation of State Medical Boards
ATTN: FCVS
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3856

NotaryCam DocID:5dedc1af13f19a52685e42fc

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Education

fsmb

Medical Education

Medical School: **University of Iowa Carver College of Medicine**

Location: Iowa City, IA
UNITED STATES

Credentials Analysis Information for Medical Education

There is no Omission/Discrepancy/Miscellaneous information identified.

The University of Iowa

ON THE RECOMMENDATION OF THE FACULTY OF THE

College of Medicine

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

Doctor of Medicine

UPON

Willie James Parker

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

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

Marvin A. Pomerantz
PRESIDENT OF THE STATE BOARD OF REGENTS

Hunter R. Rawlings III
PRESIDENT OF THE UNIVERSITY

John W. Eckstein
DEAN OF THE COLLEGE

This is to certify this is a true copy of the original diploma awarded on May 4, 1990.

Jean Lantz, M. A.
Director of Student Programs and Records

Date

SEAL VERIFIED

9125

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Postgraduate Training

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Postgraduate Training

Accreditation ID: **2203821229**
Institution: **University of Cincinnati Medical Center/College of Medicine Program**
Location: Cincinnati, OH
UNITED STATES

Accreditation ID: **3800532008**
Institution: **University of California (San Francisco)/University of California School of Publ**
Location: San Francisco, CA
UNITED STATES

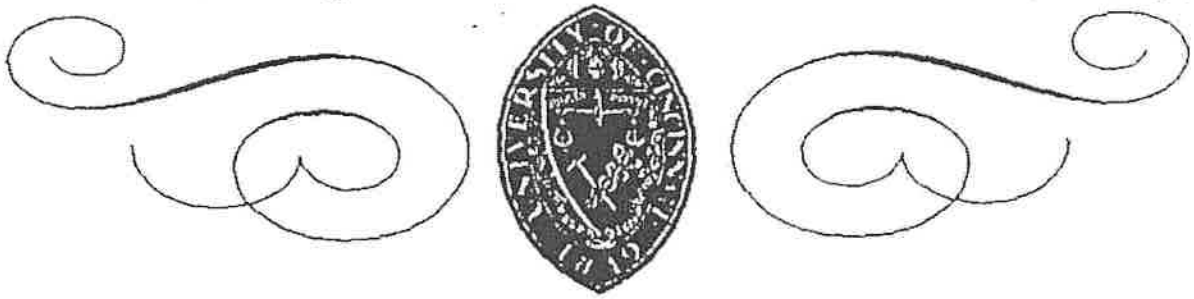
Accreditation ID: **None**
Institution: **University of Michigan Health System**
Location: Ann Arbor, MI
UNITED STATES

Credentials Analysis Information for Postgraduate Training

Issue:
The Verification of Post Graduate Training Form from University of Michigan Health System dated 07/01/2006 to 06/30/2008 reported in the Chronology of Activities is not included in the Profile.

Solution(s):
FCVS does not obtain verification of non-accredited training programs.

University of Cincinnati Medical Center
University of Cincinnati Hospital



This is to certify that

WILLIE J. PARKER, M.D.

served as a

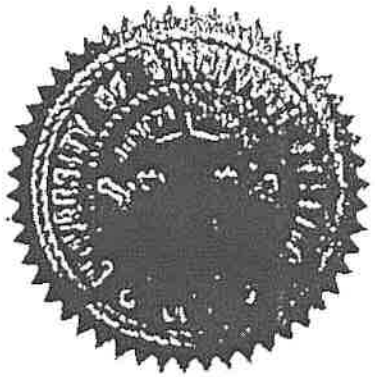
RESIDENT

in

OBSTETRICS & GYNECOLOGY

July 1, 1990 - June 30, 1994

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



Dean, College of Medicine

CEO/Director, University Hospital

Professor and Chairman, Department of Obstetrics and Gynecology

Licensure / Examinations

Exam: NewFLEX

Credential Analysis Information for Licensure / Examinations

There is no Omission/Discrepancy/Miscellaneous information identified.