William Richardson, MD

Licensed Physician #MD2014-0573

Issue Date	Expiration Date
06/13/2014	07/01/2015

Signature of Holder

The bearer is prohibited by law from using this identification card to give the impression that they are in any way connected with a governmental agency.

New Mexico Medical Board

Triennial Renewal Certificate

This is to certify that

William Richardson, MD

License Number: MD2014-0573

Having complied with the provisions of the Medical Practice Act is hereby granted a license to practice in the State of New Mexico as a Physician.

Issue Date: 06/13/2014 Date Expires: 07/01/2015*

**A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed. A lapsed license is not valid for practice in New Mexico.*

This License Must Be Conspicuously Posted In Each Practice Location

THE NEW MEXICO MEDICAL SOCIETY

NMHHSA New Mexico Hospitals & Health Systems Association

5211 $400.00

RECEIVED MAY 15 2014 NM MEDICAL BOARD

The New Mexico Statewide Application for Physician/Practitioner Appointment©

Physician (MD) Application

Date of Application: 5/8/2014 **Application Fee:** 400.00

BH#59524

Endorse

Demographics

Legal Name	Richardson (Last)	William (First)	Henry (Middle)

Other Names Used	

Will you be applying by endorsement Yes x No ____
(See page 2 of the application instructions for requirements)

Gender	M x F	**Place of Birth**	Detroit, MI	**Citizenship**	US
Immigration Status				**INS Certification #**	
***Social Security Number**	[redacted]			**Date of Birth**	[redacted]
***NM Tax ID# (if applicable)**	[redacted]		Pending ☐		
***Fed. Tax ID# (if applicable)**	[redacted]		Pending ☐		
Current Practice Name	Tucson Women's Center				
Practice Limited to: (Clinical Specialty)	Ob/gyn				
Street	5240 E. Knight #112				
City	Tucson	State	AZ	Zip Code	
Telephone Number	(520)323-9682	Facsimile	(520)323-9689		
*Office Manager or Contact Person: Elizabeth Ibarra					
Foreign Languages (spoken fluently by practitioner)	Spanish				
Foreign Languages (spoken fluently at Practice)	Spanish				
***E-Mail Address** (confidential)	Dr.Richardson@tucsonwomenscenter.com				
***Current Mailing Address** (if different from above -confidential unless no practice address indicated)					
*Street					
*City		*State		*Zip Code	
Telephone Number		Facsimile			
What are your immediate or future Practice Plans in New Mexico?	My partner has had several job offers in New Mexico, and it is now time to explore a permanent move				
Home Address (Required)	[redacted]	*Telephone Number	[redacted]		
Street	[redacted]				
*City	Tucson	*State	AZ	*Zip	85750

*Information Confidential

Practice Associates in NM (If Applicable)	Call Coverage in NM (If Applicable)
NA	NA

Other Practice Locations (If Applicable) NA					
Practice Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Answering Service		Effective Date			

Education (Please attach a separate sheet, if necessary.)

Undergraduate Education					
College or University	University of Michigan				
City	Ann Arbor	State/Country	MI	Zip Code: 48109	
Dates Attended	From: 9/1978 To: 8/1985	Degree	BS/MD	Graduation Date	8/1982 (undergradua
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	
Professional / Medical Education					
College or University	University of Michigan Medical School				
City	Ann Arbor	State/Country	MI	Zip Code: 48109	
Dates Attended	From: 09/1978 To: 08/1985	Degree	MD	Graduation Date	8/1985
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	
Graduate Education					
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	
College or University					
City		State/Country		Zip Code:	
Dates Attended	From: To:	Degree		Graduation Date	

Internship/ Residency/ Fellowship				
Institution Name	Henry Ford Hospital			
City	Detroit	State/Country	MI	Zip Code: 48202
Dates Attended	From: 9/1985 To: 8/1989	Field	Ob/gyn	
Institution Name				
City		State/County		Zip Code
Dates Attended	From: To:	Field		
Institution Name				
City		State/Country		Zip Code:
Dates Attended	From: To:	Field		
Institution Name				
City		State/Country		Zip Code:
Dates Attended	From: To:	Field		

Work History

Please list all previous practice experience for the last 15 years, **including military or government service**, listing the most recent first. If military service, state type of discharge and rank achieved **and attach copy of discharge or separation documents**. Attach separate page, if necessary. Please provide written explanation for any gaps in work history of 6 months or more.

Location	Tucson Women's Center	From 1989	To Present
Street	5240 E. Knight #112	Phone Number	(520)323-9682
City	Tucson	State AZ	Zip Code 85712
Type of Practice	Ob/gyn private practice	Contact Person	Elizabeth Ibarra
Type of Discharge		Rank Achieved	Owner
Location		From	To
Street		Phone Number	
City		State	Zip Code
Type of Practice		Contact Person	
Type of Discharge		Rank Achieved	
Location		From	To
Street		Phone Number	
City		State	Zip Code
Type of Practice		Contact Person	
Type of Discharge		Rank Achieved	
Location		From	To
Street		Phone Number	
City		State	Zip Code
Type of Practice		Contact Person	
Type of Discharge		Rank Achieved	

Hospital and Health Facility Affiliation History

(other than postgraduate training) ☐ **N/A**

Please list hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years. If an institution is no longer in existence, please provide an alternative source of verification. Use separate page, if necessary. **Providers who do NOT have admitting privileges, please explain your procedures or the arrangements you make in instances when patients require admission to a hospital. If you are applying with a health plan, should arrangements include admitting coverage by another provider, a signed letter from the covering provider, including their primary admitting facility, is to be included with this application.**

(1) Current Primary Admitting Facility (Hospital Name)	University Medical Center				
Street	1501 N. Campbell Ave				
City	Tucson	State	AZ	Zip Code	85721
Telephone Number	(520)694-0111	Facsimile	(520)694-2892		
Appointment Dates	**From:** 5/2013	**To:** Present			
Type of Appointment	Associate				
Privileges Assigned	Gyn				
(2) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(3) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					

Applicant Name William Henry Richardson **Date** 5/8/2014

(4) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(5) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(6) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(7) Facility Name					
Street					
City		State		ZIP Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					
(8) Facility Name					
Street					
City		State		Zip Code	
Telephone Number		Facsimile			
Appointment Dates	**From:**	**To:**			
Type of Appointment					
Privileges Assigned					

Professional References Please list three professional peers familiar with your professional performance in the past 5 years, (not including current or impending partners or associates in practice).

(1) Name and Title	Frank Laudonio, MD				
Address	523 N. Tucson Blvd				
City	Tucson	State	AZ	Zip Code	85716
Telephone Number	(520)323-5577	Facsimile	(520)323-5547		
(2) Name and Title	Barry Gershweir, MD				
Address	1500N. Wilmot Rd C-260				
City	Tucson	State	AZ	Zip Code	85712
Telephone Number	(520)886-4179	Facsimile	(520)886-4170		
(3) Name and Title	Marco Saucedo, MD				
Address	490 N. Carondelet Dr.				
City	Nogales	State	AZ	Zip Code	85621
Telephone Number	(520)287-2257	Facsimile	(520)287-2259		

Applicant Name William Henry Richardson **Date** 5/8/2014

Licensure-Registration-Certification Information

ECFMG Number (if applicable)							
State Professional License/Certification Number							
State		Issue Date		Expiration Date		Pending	☐

All Other State License Numbers (regardless of status - attach separate list if necessary.)

State	Number	Issue Year	Expiration Date
Arizona	18829	1989	3/30/2015

***Federal Drug Enforcement Admin. (DEA) Registration**					N/A ☐
Number	BR1915202	Exp. Date	4/30/16		Pending ☐
***State Controlled Substance Registration** (CSR)					N/A ☐
Number	PMP017895	State AZ	Exp. Date	4/20/15	Pending ☐
***Medicare Unique Physician Identification Number (UPIN)**					28408
Pending ☐					
***State Medicaid Provider Number**					NA
Pending ☐					
***National Provider Identification Number**					1326143892
Pending ☐					

Specialty Board Certifications ☐N/A

Are you Board Certified? ☒Yes ☐No **Note:** If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty, please give a brief explanation on an attached sheet.

Certified/Recertified by the:					
1. American Board of Obstetrics and Gynecology					
Date Certified	12/1992	Date Last Recertified	12/2013	Expiration Date	12/2014
2.					
Date Certified		Date Last Recertified		Expiration Date	
3.					
Date Certified		Date Last Recertified		Expiration Date	
Accepted for Examination by the:					
Until (expiration date)		If not accepted, have you made application?		Yes No	
Certified/Recertified by the Subspecialty Board of					
1.					
Date Certified		Date Last Recertified		Expiration Date	
2.					
Date Certified		Date Last Recertified		Expiration Date	
Accepted for Examination by the Subspecialty Board of					

Professional Liability Insurance (confidential information)

Do you have current liability insurance? ☒ Yes ☐ No					
Current Carrier	Mt. Hawley Insurance Company			Current ☒	Pending ☐
Address	9025 N. Lindbergh Dr. Peoria, IL 61615				
Dates Insured	From 9/12/2013	To 9/12/2014	Policy #	[redacted]	
			Coverage Limits	1M/3M	

Applicant Name William Henry Richardson, MD **Date** 5/12/2014

Licensing Exam: Please check all that apply:

☐ **State Board Exam (Prior to 1973)** Which state? _____ Date(s) passed? _____

☐ **FLEX** ☐ **LMCC** ☒ **National Board (NBME)** ☐ **USMLE**

Part/Step 1 Date Passed_____ Month/Year Part/Step 2 Date Passed_____ Month/Year Part/Step 3 Date Passed_____ Month/Year

Professional Practice Questions

Please answer all of the following Yes or No questions. If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

1. Has your professional liability coverage ever been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	Yes ☐	No ☒
2. Have you ever been denied professional liability insurance coverage?	Yes ☐	No ☒
3. Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes ☐	No ☒
4. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes ☐	No ☒
5. Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes ☐	No ☒
6. Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	Yes ☐	No ☒
7. Have you ever been named as a defendant in any criminal proceedings?	Yes ☐	No ☒
8. Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	Yes ☐	No ☒
9. Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes ☐	No ☒
10. a. Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency?	Yes ☐	No ☒
b. Have you ever agreed not to exercise your clinical privileges while under investigation?	Yes ☐	No ☒
11. Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	Yes ☐	No ☒
12. a. Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied?	Yes ☐	No ☒
b. Are any currently held licenses pending investigation or being challenged?	Yes ☐	No ☒
13. Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes ☐	No ☒
14. Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	Yes ☐	No ☒

Applicant Name William Richardson **Date** 5/8/2014

15. Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? **If yes, please provide the following information on the attached Malpractice History form for each case:** • Name, age, sex of patient/claimant. • Date(s) and type of treatment and/or surgery, which led to the allegations against you. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Disposition or current status of claim or suit (be specific). • Name of insurance carrier defending you. • Name of defense attorney.	Yes ☒	No ☐
16. Have you ever been reported to the National Practitioner Data Bank?	Yes ☐	No ☒
17. Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol?	[redacted]	
18. In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? **If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.**	[redacted]	
19. Have you ever, for any reason:		
a) Resigned from a medical school or postgraduate training (PGT) program?	Yes ☐	No ☒
b) Withdrawn from a medical school or postgraduate training program?	Yes ☐	No ☒
c) Been suspended, dismissed, or expelled from a medical school or PGT program?	Yes ☐	No ☒
d) Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program?	Yes ☐	No ☒
e) Taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or PGT program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issue, etc)?	Yes ☐	No ☒

MAY 15 2014

M MEDICAL BOA

If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

Response to question #15. Malpractice history:

To whom it may concern:

I have only had 2 malpractice suits initiated against me. The 1st was in 1996 while I worked at Thomas Davis Clinic and involved a patient who felt that she had not received informed consent prior to her tubal ligation. The second was in 1998 at Planned Parenthood of Central and Northern Arizona and involved the parent of a patient who sued Planned Parenthood for performing a D and C on her underage daughter even though the patient had forged a parental consent document. In both instances, I was dropped from the suits. Thomas Davis Clinic, and Planned Parenthood have since closed. I retained the records for the case for 10 years but discarded them after that. I therefore have no recollection or documentation other than what you now have. I have been in solo practice since 1999 and have not had any other suits.

Respectfully,

William H. Richardson, MD

New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505 (505) 476-7220

APPLICANT'S OATH

I, William H. Richardson, MD, **hereby certify that I am the person pictured below and named in this application for a license to practice as a Physician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application.**

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having control of any documents, records, and other information pertaining to me, to furnish to the Board 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 Board or their agents or representatives to inspect and make copies of such documents, records and other information, in connection with this application.

I hereby release, discharge, and exonerate the Board, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the Board. I authorize the Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.

MD 5/8/2014

Applicant Signature — Date

*Passport-quality color photograph taken within six months prior to filing the application, approximate size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.

Applicant Name William Henry Richardson **Date** 5/8/2014

American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: (214) 871-1619
Fax: (214) 871-1943

November 25, 2013

William H. Richardson, M.D.
5240 East Knight Drive
SUITE 112
Tucson, AZ 85712

Dear Doctor:

Congratulations! I am pleased to inform you that you have satisfactorily completed the 2013 Maintenance of Certification assignments. You have earned 25 AMA Category 1 CME credits. These will be awarded by the American College of Obstetricians and Gynecologists.

You should have received a 2013 MOC label insert from Jim Henry, Inc. within 60 days from the time of your MOC application.

Your certification in Obstetrics and Gynecology is valid through 12/31/2014. The ABOG MOC process is now a continuous certification process, and you must apply and participate each year.

Please use this letter to provide documentation of your certification for your hospital(s). Please remember that you must re-apply for MOC annually. The application for the 2014 program will be available through your ABOG Member Login page beginning in November, 2013.

Sincerely yours,

George D. Wendel, Jr. M.D.
Director of Maintenance of Certification

GDW

ABOG ID: 896821

AMA Physician Profile

Name and Mailing Address
WILLIAM HENRY RICHARDSON MD
5240 E KNIGHT DR STE 112
TUCSON AZ 85712-2122

Primary Office Address

SAME AS MAILING ADDRESS

Phone [redacted]

Birth date [redacted]

Physician's major professional activity OFFICE BASED PRACTICE

Self-designated practice specialty OBSTETRICS & GYNECOLOGY (primary)

UNSPECIFIED (secondary)

Self-designated practice specialties (SDPS) listed on the AMA Physician Profile do not imply recognition or endorsement of any field of medical practice by the Association nor does it imply verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.

AMA membership status NON MEMBER

All information from this point forward is provided by the primary source

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration date	Deactivation date	Reactivation date	Replacement number	Last reported date
1326143892	09/13/2006	NOT RPTD	NOT RPTD	NOT RPTD	04/26/2014

Current and/or historical medical school

UNIV OF MI MED SCH, ANN ARBOR MI 48109
Degree Awarded: Yes
Degree Year: 1985

AMA AMERICAN MEDICAL ASSOCIATION

Current and/or historical post graduate medical training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

Sponsoring Institution: HENRY FORD HOSP
Sponsoring State: MICHIGAN
Specialty: OBSTETRICS & GYNECOLOGY
Dates: 07/1986 - 06/1989 (Verified)

Sponsoring Institution: HENRY FORD HOSP
Sponsoring State: MICHIGAN
Specialty: OBSTETRICS & GYNECOLOGY
Dates: 07/1985 - 06/1986 (Verified)

If you have discrepant information, please submit a Request for Investigation to the AMA so that we may verify the information with the primary source(s). See the last page of this Profile for instructions on how to report a data discrepancy.

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 1986

Current and/or historical medical licensure

Jurisdiction	MD/ DO	Date granted	Expiration date	Status	License type	Last reported
ARIZONA	MD	06/09/1989	07/30/2016	ACTIVE	UNLIMITED	05/05/2014
MICHIGAN	MD	01/01/1988	NOT RPTD	INACTIVE	UNLIMITED	08/25/2003

ECFMG Certfication

Applicant Number:

The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at ***https://cvsonline2.ecfmg.org/***

AMA AMERICAN MEDICAL ASSOCIATION

U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration date	Last Reported date	Address:
[redacted]	2N 33N 4 5	04/30/2016	05/05/2014	Ste 112, 5240 E Knight Dr, Tucson, AZ 85712-2122

Only the last three characters of active DEA numbers are displayed

Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

Specialty Board Certification

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

Certifying board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
Certificate: OBSTETRICS & GYNECOLOGY
Certificate type: GENERAL

Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date
TIME LIMITED	12/31/2013	12/31/2014		RE-CERT	05/07/2014
TIME LIMITED	12/31/2012	12/31/2013		RE-CERT(**)	05/07/2014
TIME LIMITED	12/31/2011	12/31/2012		RE-CERT(**)	05/07/2014
TIME LIMITED	12/31/2010	12/31/2011		RE-CERT(**)	05/07/2014
TIME LIMITED	12/31/2009	12/31/2010		RE-CERT(**)	05/07/2014
TIME LIMITED	12/31/2008	12/31/2009		RE-CERT(**)	05/07/2014
TIME LIMITED	12/31/2007	12/31/2008		RE-CERT(**)	05/07/2014
TIME LIMITED	12/31/2006	12/31/2007		RE-CERT(**)	05/07/2014
TIME LIMITED	12/31/2005	12/31/2006		RE-CERT(**)	05/07/2014

AMA AMERICAN MEDICAL ASSOCIATION

Certifying board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
Certificate: OBSTETRICS & GYNECOLOGY
Certificate type: GENERAL

Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date
TIME LIMITED	12/31/2004	04/30/2006		RE-CERT(**)	05/07/2014
TIME LIMITED	12/31/2003	04/30/2005		RE-CERT(**)	05/07/2014
TIME LIMITED	12/31/2002	04/30/2004		RE-CERT(**)	05/07/2014
TIME LIMITED	12/11/1992	12/31/2002		INITIAL(**)	05/07/2014

For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information.

Action notifications

To date, there have been no actions reported to the AMA by any US state licensing agency.

To date, there have been no Medicare/Medicaid sanctions reported to the AMA by the Department of Health and Human Services.

To date, there have been no federal sanctions reported to the AMA by any branch of the US military, the Veteran's Adminstration or the US Public Health Service.

AMA
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ASSOCIATION

Additional Information

To date, there is no additional information for this physician on file.

The content of the AMA Physician Profile is intended to assist with credentialing. An organization's appropriate use of the data contained in the AMA Physician Masterfile meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission (AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA Physician Masterfile is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

If any of the data in this Profile is believed to be incorrect, please log onto our website **(www.ama-assn.org/go/amaprofiles)** and go to the order detail page. Select the 'D' following the physician's name and enter the data in questions. Or you can mark the issues on a copy of the profile and mail or fax to:

American Medical Association
Division of Database Products
Attn: Physician Products Portfolio
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

Fax: (312) 464-5900

If you have any questions or need additional information about the AMA Physician Profile Service, please call (800) 665-2882.

The Federation of State Medical Boards
of the United States, Inc.
PO Box 619850
Dallas, Texas 75261-9850
Telephone: (817) 868-4000
FAX (817) 868-4099

BOARD ACTION CLEARANCE REPORT

May 16, 2014

New Mexico Medical Board
Attn: Lynn S. Hart, Executive Director
2055 S. Pacheco St, Ste 400
Santa Fe, NM 87505-0503

Re: Board Action Query Dated: May 16, 2014
Your Reference Number:
FSMB Batch Number: [redacted]

The following is a report of the search results from the Board Action Data Bank as of May 16, 2014 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Practitioners Cleared with No Actions as of May 16, 2014

Item	Name	DOB	School	Yr/Grad	Request ID
2	Blumenthal, Paul	03/01/1952	014020	1977	27324503
		LICENSE HISTORY State Board CALIFORNIA MARYLAND			
1	Brown, Megan	07/21/1988	099722	2014	27324501
		LICENSE HISTORY State Board No License Information Available			
4	Richardson, William	[redacted]	023030	1985	27324522
		LICENSE HISTORY State Board ARIZONA MICHIGAN			
3	Rush, Sloan	05/10/1980	044070	2005	27324505
		LICENSE HISTORY State Board OREGON TEXAS			

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

PROFESSIONAL RECOMMENDATION

The New Mexico Medical Board requires the completion of this Professional Recommendation by a physician or a Chief of Staff or a Department Chief with whom I have worked and who has personal knowledge of my character and competence to practice medicine. This form is required as part of my application for licensure. *All* elements in the section below ***must*** be completed. The lower half of the form may be used for narrative comment. This is my authorization to release all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Applicant's Name: William H. Richardson, MD Date of Birth [redacted]

Applicant's Signature: [signature] Date: 5/12/2014

Address: [redacted] City Tucson State AZ

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PHYSICIAN
The information on this form is NOT a public document.

1. Date and type of service: This individual served with me as Colleague

from 6/1992 (Month/Year) to 2007 (Month/Year) at 5240 E. Kayenta #112 (Location)

2. Please evaluate:

	(Please indicate with check mark)			
	Poor	Fair	Good	Superior
Professional knowledge				X
Clinical judgment				X
Relationship with patients				X
Ethical/professional conduct				X
Ability to communicate				X
Clinical skills				X

3. Recommendation: (please indicate with a check mark)

1. Recommend highly and without reservation X
2. Recommend as qualified and competent
3. Recommend with some reservation (explain)
4. Concerns (explain)

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments.

Excellent knowledge, caring, organized + very intelligent. Cooperative + friendly.

5. The above report is based on: (please indicate with check mark)

1. Close personal observation X
2. General impression
3. A composite of evaluations
4. Other Private Practice

Name (Please Print): [redacted] Title: Owner Phone: [redacted]

Signature: [signature] M.D. Date: 5/12/14

Revised 8/2008

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PROFESSIONAL RECOMMENDATION

The New Mexico Medical Board requires the completion of this Professional Recommendation by a physician or a Chief of Staff or a Department Chief with whom I have worked and who has personal knowledge of my character and competence to practice medicine. This form is required as part of my application for licensure. ***All*** elements in the section below ***must*** be completed. The lower half of the form may be used for narrative comment. This is my authorization to release all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Applicant's Name: William H. Richardson, MD Date of Birth [redacted]

Applicant Signature: [signature] Date: 5/12/2014

Address: [redacted] City Tucson State AZ

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PHYSICIAN
The information on this form is NOT a public document.

1. Date and type of service: This individual served with me as COLLEAGUE

from 7/94 (Month/Year) to PRESENT (Month/Year) at TUCSON MEDICAL ASSOCIATES - THOMAS-DAVIS MEDICAL CENTER - PRIVATE PRACTICE (Location)

2. Please evaluate:

	(Please indicate with check mark) Poor	Fair	Good	Superior
Professional knowledge				X
Clinical judgment				X
Relationship with patients				X
Ethical/professional conduct				X
Ability to communicate				X
Clinical skills				X

3. Recommendation: (please indicate with a check mark)

1. (✓) Recommend highly and without reservation
2. Recommend as qualified and competent
3. Recommend with some reservation (explain)
4. Concerns (explain)

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments.

5. The above report is based on: (please indicate with check mark)

1. Close personal observation ✓
2. General impression
3. A composite of evaluations
4. Other

Name (Please Print): [redacted] Title: ATTENDING PHYSICIAN Phone: [redacted]

Signature: [signature] MD Date: 5/14/14

Arizona Medical Board

General Information

William Richardson
[redacted]
Tucson AZ 85712-2122
Phone: (520) 323-9682

License Number: 18829
License Status: Active
License Date: 06/09/1989
License Renewed: 03/03/2014
Due to Renew By: 03/30/2016
If not Renewed, License Expires: 07/30/2016

Education and Training

Medical School:	UNIV OF MI MED SCH Ann Arbor, Michigan
Graduation Date:	06/28/1985
Residency:	07/01/1985 - 06/30/1989 (Obstetrics & Gynecology) HENRY FORD HEALTH SYSTEM DETROIT, MI
Area of Interest:	Obstetrics & Gynecology

The Board does not verify current specialties. For more information please see the American Board of Medical Specialties website at http://www.abms.org to determine if the physician has earned a specialty certification from this private agency.

Board Actions

None

This license information was last updated on: 05/13/2014

A person may obtain additional public records related to any licensee, including dismissed complaints and non-disciplinary actions and orders, by making a written request to the Board. The Arizona Medical Board presents this information as a service to the public. The Board relies upon information provided by licensees 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 reliability of the content of this website or the content of any other website to which it may link. Assessing accuracy and reliability of the information obtained from this website is solely the responsibility of the user. The Board is not liable for errors or for any damages resulting from the use of the information contained herein.

Please note that some Board Actions may not appear until a few weeks after they are taken, due to appeals, effective dates and

Board actions taken against physicians in the past 24 months are also available in a chronological list.

LARA Department of Licensing and Regulatory Affairs

MICHIGAN.GOV Michigan's Official Web Site

Bureau of Health Care Services

Verify a License/Registration

Name and Address

Name : WILLIAM H RICHARDSON
Address : Tucson, AZ 85715

Profession and License/Registration Information

Profession : Medicine **Type :** Medical Doctor

Permanent ID #	Status	Issue Date	Expiration Date
[redacted]	Lapsed	12/19/1988	01/31/1993

Complaints and Disciplinary Action

Open Formal Complaints : None
Disciplinary Action : None

Images

Document Type	Complaint Number	Document Year
No Images Found for record		

New Search Return to Search

The data on this web page is refreshed daily.

DISCLAIMER

The **Issue Date** is the date the license/registration was first issued. Please note this information is not always available in the database. The **Expiration Date** given above is the date the license/registration expired or will expire. The license/registration may not have been active from the **Issue Date** to the **Expiration Date**. There may have been periods of non-licensure or registration.

For those licensees/registrants who have actions listed in the **Disciplinary Action** section above, the date the licensee/registrant complied with their board order is listed for all disciplinary actions subsequent to January 1, 2005. The date of compliance is not listed for disciplinary actions that began prior to that date. You should check with our office to confirm the status of the cases if the date of compliance is not listed.

You may request additional information under the Freedom of Information Act (FOIA) at 517-373-6637 (phone), 517-241-2635 (fax) or BHCS-FOIAINFO@michigan.gov for directions on how to obtain more information regarding the license/registration history or disciplinary actions.

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WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

William Richardson, MD
[redacted]
Address
Tucson, AZ 85712
City/State/Zip

Applicant Signature
5/31/2013
*Dates of Privilege/Employment must match to form(s) (must be provided)
[redacted]
Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are *NOT* accepted in lieu of this form.

Kathryn Reed, MD
Type or Print Name of person completing this form
Ob/gyn Department Chair
Title
University of Arizona Medical Center
Name of Institution
1501 N. Campbell
Address
Tucson, AZ 85721
City / State / Zip

1. This evaluation is based on: ✓ Observation of applicant ___ Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes ✓No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes ✓No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes ✓No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ___Yes___No NA

If not, please provide correct dates: Beginning _____ Month/Year Ending _____ Month/Year

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

K Reed 5/15/14
Printed name of person completing this form — Signature — Date

Please affix hospital or notary seal here

Signature of Notary (if applicable) — Date

My commission expires: _____

Please note on this form if there is no hospital or notary seal available.
Please return this form directly to the address above
Thank you for your cooperation.

Revised 8/2008