

# PHOTOGRAPH

MBC  
Use Only

Rev L1A-F  
Staff Initials  
& Date

Photograph

Applicant  
Name & DOB

Applicant  
Signature  
& Date

Applicant  
Signature

Applicant  
Name &  
Notary Date

Notary  
Signature  
& Seal

# L1F

**Photograph**  
Affix a 2" X 2" Photo Here  
Photo Must Be Recent and  
Must Be of your Head and  
Shoulder Areas Only  
Altered Photographs  
are NOT Acceptable

Notice: All items in this application are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensing per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

# DECLARATION

The applicant, \_\_\_\_\_, **PRINT LEGAL NAME (First, Middle, Last, Suffix)**, \_\_\_\_\_, **DATE OF BIRTH (mm/dd/yyyy)**

being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same 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 and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

**I UNDERSTAND THAT ANY OMISSION, FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.**

**SIGN LEGAL NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

# NOTARY SECTION

**SIGNATURE OF APPLICANT:** \_\_\_\_\_  
(SIGN LEGAL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of \_\_\_\_\_

County of \_\_\_\_\_

Subscribed and sworn to (or affirmed) before me on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,

by, \_\_\_\_\_ proved to me on the basis of satisfactory evidence  
(PRINT APPLICANT'S LEGAL NAME)

to be the person who appeared before me.

**NOTARY SEAL**

\_\_\_\_\_  
**SIGNATURE OF NOTARY PUBLIC**