MEDICAL BOARD OF CALIFORNIA

Licensing Program

APPLICATION FOR CANCELLATION OF A FICTITIOUS NAME PERMIT

Please print or type.

Illegible applications will be returned.

Fictitious Name:				
Fictitious Name Permit Number:				
Expiration Date:				
Practice Address:				
Contact Person's Name:				
Address:				
Contact's Telephone Number: FAX Number (if applicable):			FAX:	
Reasons for Cancellation:	☐	Out of Business	☐	Change in Ownership
	☐	Dissolution of Solo Practice	☐	Dissolution of Partnership
	☐	Dissolution of Group	☐	Dissolution of Corporation
	☐	Change in original filing status	☐	Other:

NOTICE: All items in this application are mandatory, none is voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to verify and identify the licensee's identification per Sections 118 and 2432 of the Business and Professions Code. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Licensing Program chief is the custodian of records. Information provided in this application may be transferred to other governmental or law enforcement agencies.

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 274-6181 www.mbc.ca.gov

BOTH PAGES OF THIS FORM MUST BE COMPLETED.

FOR INDIVIDUALS (SOLE PROPRIETORS), GROUPS, AND PARTNERSHIPS ONLY

The following must be signed by a licensed physician and surgeon or podiatrist who is recognized by the Medical Board as being a current owner of the Fictitious Name Permit.

I am/was an owner who holds the permit _____
(COMPLETE FICTITIOUS NAME)

and as such declare that I am authorized to act on behalf of all other owners and that said owners are aware that this application is being submitted to the Medical Board of California's Licensing Program for the cancellation of the fictitious name permit named in this application. I have read the foregoing application and all attachments thereto and know the contents thereof, and the same are true of my own knowledge. I certify under penalty of perjury under the laws of the State of California that the information I have provided is true and correct.

Executed at _____, California, this ___ day of _____, 20___

BY:

NAME (please type or print)	SIGNATURE	MEDICAL LICENSE #

FOR CORPORATIONS ONLY

The following must be signed by a licensed physician and surgeon or podiatrist who is recognized by the Medical Board as being a current owner of the Fictitious Name Permit.

I am/was a shareholder of _____
(COMPLETE CORPORATE NAME)

and as such declare that I am authorized to act on behalf of the corporation and that all corporate officers and shareholders are aware that this application is being submitted to the Medical Board of California's Licensing Program for the cancellation of the fictitious name permit named in this application. I have read the foregoing application and all attachments thereto and know the contents thereof, and the same are true of my own knowledge. I certify under penalty of perjury under the laws of the State of California that the information I have provided is true and correct.

Executed at _____, California, this ___ day of _____, 20___

BY:

NAME (please type or print)	SIGNATURE	MEDICAL LICENSE #

FICTITIOUS NAME:	FICTITIOUS NAME PERMIT NUMBER: