MEDICAL BOARD OF CALIFORNIA

Licensing Program

POSTGRADUATE TRAINING REGISTRATION FORM

To be completed by every medical graduate who is not licensed in California and who will commence an ACGME accredited postgraduate training program in California. Please complete the information below and return this form to the Licensing Program of the Medical Board of California at the below address. The filing of this form with the Board will fulfill the registration requirements specified in Sections 2065 and 2066 of the Business and Professions Code.

Check one: ☐ **U.S. or Canadian Medical School Graduate** ☐ **International Medical School Graduate**

1. Legal Name	Last	First	Middle Suffix
2. Date of Birth (mm/dd/yyyy)		**3. U.S. SSN or ITIN**	
4. Mailing Address			
5. Telephone Numbers	Home:	Work:	Cell:
6. E-mail Address			
7. Name and Address of Medical School of Graduation			
8. Issue Date of Medical Degree (mm/dd/yyyy)			
9. Is this your first accredited postgraduate training year in the U.S.?	☐ Yes ☐ No		
10. If no, list all other ACGME/RCPSC accredited postgraduate training programs in which you participated, whether or not the program was completed or credit was granted. Include dates of training.			
11. Name and address of the facility where training is to be completed.			
12. Name of Program Director	**13. Email of Program Director**	**14. Telephone Number of Program Director**	
15. Specialty Area of Training	**16. ACGME 10-digit Program Number**		
17. Dates of Training	Start Date:	End Date:	

I hereby declare under penalty of perjury under the laws of the State of California that I have read the laws, and that the foregoing information contained in this document is true and correct.

SIGN LEGAL NAME: _____ DATE: _____

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2487 www.mbc.ca.gov