



## MEDICAL BOARD OF CALIFORNIA Licensing Program



### ADDENDUM TO QUESTION #16

This form may be used to provide ACGME/RCPSC accredited postgraduate training information if you require additional space in response to question #16 on Form L1C.

Type or Print Legibly					PERSONAL INFORMATION				
<b>LEGAL NAME:</b>		Last	First	Middle	Suffix				
<b>Date of Birth</b> (mm/dd/yyyy)		<b>U.S. SSN or ITIN</b>			<b>Medical School of Graduation</b>				
ADDITIONAL POSTGRADUATE TRAINING INFORMATION									
Facility Name		City, State/Province		Specialty		Dates of Training (mm/dd/yyyy to mm/dd/yyyy)			
						Start			
						End			
						Start			
						End			
						Start			
						End			
						Start			
						End			
SIGN LEGAL NAME: _____ DATE: _____ <p style="text-align: center; margin-top: 10px;"><b>Applicant's signature and date are required.</b></p>									