MEDICAL BOARD
OF CALIFORNIA
Protecting consumers by advancing high quality, safe medical care.

Licensing Program
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Governor Edmund G. Brown Jr., State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

CERTIFICATE OF MEDICAL EDUCATION

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

Type or Print Legibly

APPLICANT INFORMATION

LEGAL NAME: Last | First | Middle | Suffix

Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School of Graduation

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

NOTE: If the applicant had an accelerated or extended curriculum, withdrew from this institution, or was accepted with advanced standing, a letter of explanation from a school official is required. The letter must be on medical school letterhead, signed by a school official, and be mailed directly to the Board from the medical school.

1. Name of Medical School
2. State/Province/Country
3. The undersigned further certifies that the records of this institution show that the applicant attended in this institution _____ ***years*** of resident instruction, completing at least 4,000 hours, of which at least 80 percent actual attendance is required in the subjects set forth hereunder (Business and Professions Code Sections 2089, 2089.5, 2089.7, 2090, 2091.1, 2091.2).

Alcoholism and Chemical Dependency	**Geriatric Medicine**	**Otolaryngology**	**Psychiatry**
Anatomy	**Histology**	**Pain Management and End-of-Life-Care****	**Radiology, including Radiation Safety**
Anesthesia	**Human Sexuality**	**Pathology, Bacteriology, and Immunology**	**Spousal Partner Abuse Detection & Treatment*****
Biochemistry	**Medicine**	**Pediatrics**	
Child Abuse Detection and Treatment	**Neuroanatomy**	**Pharmacology**	**Surgery, including Orthopedic Surgery**
Dermatology	**Neurology**	**Physical Medicine**	**Therapeutics**
Embryology	**Obstetrics and Gynecology**	**Physiology**	**Tropical Medicine**
Family Medicine*	**Ophthalmology**	**Preventative Medicine, including Nutrition**	**Urology**

***ONLY applicable to medical students who enrolled in medical school on or after May 1, 1998**
****ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000**
*****ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994**

4. Did the applicant withdraw or transfer from this medical school? ☐ Yes ☐ No
5. What is the standard duration of the curriculum at this institution? years
6. Date the applicant was enrolled in medical school? (mm/dd/yyyy)
7. Date the applicant was issued the diploma of Bachelor/Doctor of Medicine (mm/dd/yyyy)

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

Any "Yes" response below requires a signed and dated letter of explanation by school official.

8. Did this applicant ever take a leave of absence from his/her medical education? ☐ Yes ☐ No
9. Was this applicant ever placed on probation? ☐ Yes ☐ No
10. Was this applicant ever disciplined or placed under investigation? ☐ Yes ☐ No
11. Were any limitations or special requirements imposed on this applicant because of questions of academic or disciplinary problems, or for any other reason? ☐ Yes ☐ No

MEDICAL SCHOOL OFFICIAL CERTIFICATION

AFFIX MEDICAL SCHOOL SEAL

I certify that I am the President, Dean, or Registrar and hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.

PRINTED NAME OF SCHOOL OFFICIAL | **TITLE OF SCHOOL OFFICIAL**

SIGNATURE OF SCHOOL OFFICIAL | **DATE**

Attention Medical School: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

MBC Use Only

Applicant Information ❒

Medical School Information

School Code

❒

❒

Rev. L2 Staff Initials & Date

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❒

❒

❒

Unusual Circumstances

❒

❒

❒

❒

School Seal ❒

Signature and Date ❒

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NOTE: The completed form must be mailed directly from the medical school to the Board to be acceptable.