



MEDICAL BOARD OF CALIFORNIA Licensing Program

CURRENT POSTGRADUATE TRAINING ENROLLMENT

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

Type or Print Legibly APPLICANT INFORMATION				MBC Use Only	
LEGAL NAME: Last		First	Middle	Suffix	Applicant Information <input type="checkbox"/>
Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN		Medical School of Graduation		
PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION					
Facility Name					Verified Program Information <input type="checkbox"/>
Facility Address					
Specialty	ACGME 10-digit Program # https://apps.acgme.org/ads/Public				
Dates of Training (mm/dd/yyyy)	Start Date:	Anticipated Completion Date:			
PROGRAM DIRECTOR OFFICIAL CERTIFICATION					Verified PD Staff Initials & Date Program Director's Signature & Date <input type="checkbox"/> Program Director's Signature <input type="checkbox"/>
ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM <u>MAY NOT</u> BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director may sign this form. If that signature authority 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.					
<i>I hereby declare under penalty of perjury under the laws of the State of California that the information contained on this form is true and correct. I further certify that the training program is accredited by the ACGME or the RCPSC to offer the type and level of training to the above named applicant and that the applicant is actively participating in a slotted position in an accredited ACGME or RCPSC postgraduate training program.</i>					
_____ PRINTED NAME OF PROGRAM DIRECTOR					
_____ SIGNATURE OF PROGRAM DIRECTOR (Signature Stamp Is Not Acceptable)			_____ DATE		
NOTE: If a hospital seal is not available, the program director shall also sign in the section below in the presence of a notary public.					Hospital Seal <input type="checkbox"/>
SIGNATURE OF PROGRAM DIRECTOR: _____ (SIGN FULL 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 PROGRAM DIRECTOR'S NAME) to be the person who appeared before me.					
_____ SIGNATURE OF NOTARY PUBLIC				<div style="border: 1px solid black; width: 100px; height: 100px; margin: 0 auto;"> HOSPITAL or NOTARY SEAL </div>	

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