# MEDICAL BOARD OF CALIFORNIA
**Licensing Program**

# Certificate of Individual Clinical Clerkship Training

**This form is required of international medical school graduates who completed any clinical training outside of the primary teaching hospital of their medical school. A separate form is to be used for each clinical clerkship.**

**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 |
|---|---|---|
| | | |

## PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR TO COMPLETE CLERKSHIP INFORMATION

| Facility Name | Facility Address |
|---|---|
| | |
| **Clinical Specialty** | **Dates of Training** (mm/dd/yyyy) |
| | Start Date: End Date: |

This facility **is** formally affiliated or has a formal contract of affiliation with a U.S., Canadian, or International Medical School. ☐ Yes ☐ No

Name of the U.S., Canadian, or International Medical School. **(If affiliated)**

This facility **does** have an ACGME-accredited residency training program. ☐ Yes ☐ No

ACGME 10-digit program # (https://apps.acgme.org/ads/Public): Specialty:

## OFFICIAL CERTIFICATION

**ATTENTION: A signature stamp is not acceptable. THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director or clinical instructor 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 certify that I am the program director or clinical instructor and that the applicant named above satisfactorily completed the above named clinical clerkship and I 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 PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR**

_____ _____
**SIGNATURE OF PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR** **DATE**

**NOTE: If a hospital seal is not available, the program director or clinical instructor shall also sign in the section below in the presence of a notary public.**

**Signature of Program Director or Clinical Instructor:** _____
**(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 Name of Program Director or Clinical Instructor)**

to be the person who appeared before me.

**HOSPITAL or NOTARY SEAL**

_____
**SIGNATURE OF NOTARY PUBLIC**

MBC Use Only

Applicant Information ☐

Verified Information with L5 ☐

Clerkship Approved

Rev L6 Staff Initials & Date

Signature & Date ☐

Signature ☐

Notary Signature & Seal ☐

Hospital Seal ☐

**L6**

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



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