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 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.

_____
SIGNATURE OF NOTARY PUBLIC

HOSPITAL or NOTARY SEAL

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.