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

Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
Fax: (916) 263-2487
www.mbc.ca.gov

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

APPLICATION

TYPE OF APPLICATION

(Check One)

- ☐ U.S. or Canadian Medical School Graduate
- ☐ International Medical School Graduate

(Check All That Apply)

- ☐ Physician's and Surgeon's License
- ☐ Postgraduate Training Authorization Letter (PTAL)
- ☐ Update Application: File #
- ☐ Limited Practice License

MBC Use Only — Application Type ☐

PRIORITY REVIEW & EXPEDITED LICENSURE

☐ **Honorably Discharged Veterans of the Armed Forces -** Must supply satisfactory evidence to the Board that you have served as an active duty member of the Armed Forces of the United States and were honorably discharged.

☐ **Practice in Medically Underserved Area or Population -** Must supply satisfactory evidence to the Board that you have accepted employment and intend to practice in an area of California formally designated as an underserved area or underserved population. Please see further details on our website at http://www.mbc.ca.gov/Applicants/Physicians_and_Surgeons/Underserved.aspx.

☐ **Temporary License for Spouse of Active Duty Member of the Armed Forces -** Must supply satisfactory evidence to the Board that you are married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders. In addition, you must meet the requirements listed in Business and Professions Code Section 115.6.

Priority Review ☐

PERSONAL INFORMATION

Type or Print Legibly

1. Legal Name	Last	First	Middle	Suffix
2. Other Names/Alias				
3. United States Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN)		☐ SSN ☐ ITIN		
4. Date of Birth	(mm/dd/yyyy)	**5. Gender**	☐ Male ☐ Female	

Legal Name ☐ SSN/ITIN ☐ DOB ☐ Gender ☐

6. Address of Record

This address will be used for all current correspondence during the review process and will be posted on the Board's website upon issuance of a license.

If you are using a P.O. Box please list a confidential street address below.

Mailing Address *(40 characters maximum per line, including spaces)*

Mailing Address continued *(40 characters maximum per line, including spaces)*

City | State/Province | Zip/Postal Code | Country

Address of Record ☐

Confidential Address
(Only required if Address of Record is a P.O. Box)

Confidential Address ☐

7. Telephone Numbers	Home #	Work #	Cell #

Telephone Numbers ☐

8. E-mail Address (Required)

Email ☐

9.	Have you served or are you currently serving in the military?	☐ Yes ☐ No
10.	Are you requesting expediting of this application as a spouse or domestic partner of an active duty member of the Armed Forces?	☐ Yes ☐ No

Military ☐ ☐

MBC Use Only			
Cashiering		Pathway	School Code

L1A

APPLICANT: (Print Legal Name)	DATE OF BIRTH: (mm/dd/yyyy)

MBC Use Only ❒ Name & DOB

PREVIOUS APPLICATION OR LICENSE

NOTE: A "yes" response to question 11 requires a signed and dated written explanation. The *Explanation For Application Question* form may be used to provide your explanation.

11. Have you ever filed an application for a Physician's and Surgeon's License or a PTAL in California that has been withdrawn, abandoned, or denied?	☐Yes ☐No
12. Have you previously held a Physician's and Surgeon's License in California? If yes, please provide license number: _____ Expired: _____	☐Yes ☐No

Previous App/License ❒ ❒

EXAMINATIONS

13. Are you certified by the Educational Commission for Foreign Medical Graduates?	☐Yes ☐No

ECFMG ❒

14. List all of the following examinations you have taken and passed: **USMLE, FLEX, NBME, LMCC and/or STATE BOARDS**

Examination	Date Passed

Exams ❒ ❒ ❒ ❒ ❒

MEDICAL EDUCATION

NOTE: To be eligible for a PTAL or License, all schools attended must be on the Board's list of recognized or approved medical schools. If you did not attend or graduate from a recognized or approved medical school, you may be eligible for licensure pursuant to Section 2135.7 of the Business and Professions Code. To view the Board's list of recognized or approved medical schools, please refer to our website at: http://www.mbc.ca.gov/Applicants/Medical_Schools/Schools_Recognized.aspx.

15. List each medical school that you have attended and the medical school of graduation.

Medical Education

Medical School Name	Mailing Address		Dates of Attendance (mm/dd/yyyy)
		Start	
		End	
		Start	
		End	
		Start	
		End	

L2 ❒ Trans ❒ School Code

Medical School of Graduation	Title of Degree Awarded	Issue Date of Degree (mm/dd/yyyy)

Diploma ❒

L1B

APPLICANT: (Print Legal Name)	DATE OF BIRTH: (mm/dd/yyyy)	MBC Use Only ❒ Name & DOB

ACGME or RCPSC ACCREDITED POSTGRADUATE TRAINING PROGRAMS
(Internship, Residency and Fellowship Programs)

16. Have you participated in any ACGME-accredited postgraduate training programs in the United States or RCPSC-accredited postgraduate training in Canada?	(*If NO, please skip to question #24*) ☐ Yes ☐ No	PG Training Programs ❒

List every program (internship, residency and fellowship) in which you have participated or are currently participating, regardless of whether the program was completed or any credit was granted.
(Use the *Addendum to Question #16 Form* if additional space is needed)

Facility Name	City, State/Province	Specialty	Dates of Training (mm/dd/yyyy)	
			Start	
			End	❒
			Start	
			End	❒
			Start	
			End	❒

NOTE: A "yes" response to question 17-23 requires a signed and dated written explanation. The *Explanation For Application Question* form may be used to provide your explanation.

17. Have you ever received partial or no credit for a postgraduate training program?	☐Yes ☐No	❒
18. Have you ever taken a leave of absence or break from your training?	☐Yes ☐No	❒
19. Have you ever been terminated, dismissed or expelled from a program?	☐Yes ☐No	❒
20. Have you ever been placed on probation for any reason?	☐Yes ☐No	❒
21. Have you ever been disciplined or placed under investigation?	☐Yes ☐No	❒
22. Have you ever had any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	☐Yes ☐No	❒
23. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	☐Yes ☐No	❒

MEDICAL LICENSE

24. Have you ever held or do you currently hold a medical license in any U.S. state, U.S. territory, or Canadian province?	☐Yes ☐No	License ❒

List medical license information for all licenses ever held below. Do not list temporary, training, or provisional licenses. (Use the *Addendum to Question #24 Form* if additional space is needed.)

U.S. State, U.S. Territory or Canadian Province	License Number	Dates of Practice (mm/yyyy to mm/yyyy)	
		to	❒
		to	❒
		to	❒
		to	❒

L1C

APPLICANT: (Print Legal Name)	DATE OF BIRTH: (mm/dd/yyyy)	MBC Use Only ❒ Name & DOB

ABMS CERTIFICATION

25. Are you currently certified by a Member Board of the American Board of Medical Specialties?	☐ Yes ☐ No	ABMS ❒

MALPRACTICE HISTORY

26. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement, judgment, or arbitration?	☐ Yes ☐ No	Malpractice History ❒

DISCIPLINARY HISTORY

These questions refer to discipline by any hospital, Military or Public Health Service, State Board, or other Governmental Agency of any U.S. state, U.S. territory, Canadian province, or foreign country.

Disciplinary History

27. Have you ever had your DEA privileges denied, suspended, restricted, or terminated?	☐ Yes ☐ No	❒
28. Have you ever entered into any arrangement, agreement or plea in lieu of federal prosecution with the DEA to resolve an alleged violation of a federal or state drug statute or regulation?	☐ Yes ☐ No	❒
29. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?	☐ Yes ☐ No	❒
30. Have you ever been denied a license to practice medicine?	☐ Yes ☐ No	❒
31. Is any denial pending against you?	☐ Yes ☐ No	❒
32. Have you ever had any license to practice medicine subjected to any disciplinary action?	☐ Yes ☐ No	❒
33. Is any disciplinary action pending against any of your licenses to practice medicine?	☐ Yes ☐ No	❒
34. Have you ever surrendered a license to practice medicine?	☐ Yes ☐ No	❒
35. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	☐ Yes ☐ No	❒
36. Have you ever had any license to practice medicine subjected to any action including, *but not limited to*, informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?	☐ Yes ☐ No	❒
37. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital?	☐ Yes ☐ No	❒
38. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	☐ Yes ☐ No	❒
39. Is any disciplinary action pending against your hospital or staff privileges?	☐ Yes ☐ No	❒
40. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	☐ Yes ☐ No	❒
41. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?	☐ Yes ☐ No	❒

NOTE: A "yes" response to question 26-41 requires a signed and dated written explanation. The *Explanation For Application Question* form may be used to provide your explanation.

L1D

APPLICANT: (Print Legal Name)	**DATE OF BIRTH:** (mm/dd/yyyy)	MBC Use Only ❒ Name & DOB

CRIMINAL RECORD HISTORY

Applicants who answer "NO" to the questions below, but have a previous conviction or plea, may have their application denied for knowingly falsifying the application. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application.

For each conviction, you must submit certified copies of the arresting agency report, certified copies of the court documents (court docket) and a signed and dated descriptive explanation of the circumstances surrounding the conviction (i.e., dates and location of the incident and all circumstances surrounding the incident). If the documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is required. In addition, you may submit evidence of rehabilitation.

Criminal History

42. Have you ever been convicted of, or pled guilty or nolo contendere to **ANY** offense in the United States, its territories, or a foreign country? ***This includes every citation, infraction, misdemeanor and/or felony, including traffic violations. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b), (c), (d), (e), or section 11360(b) which are two years or older should NOT be reported. Convictions that were later expunged from the record of the court or set aside pursuant to section 1203.4 of the California Penal Code or equivalent non-California law MUST be disclosed.***	☐ Yes ☐ No	❒
43. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357(b), (c), (d), (e), or section 11360(b) which are two years or older, have you had a charge or conviction that was set aside or later expunged from the record of the court?	☐ Yes ☐ No	❒
44. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?	☐ Yes ☐ No	❒
45. Are you a registered sex offender?	☐ Yes ☐ No	❒

PRACTICE IMPAIRMENT OR LIMITATIONS

An affirmative answer to any of the questions below will require the Board to make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are eligible for licensure. Please note that a Limited Practice License may be available. Refer to the *Application Information for a Limited Practice License* for further information.

Limitations

46. Have you ever been enrolled in, required to enter into, or participated in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?	☐ Yes ☐ No	❒
47. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?	☐ Yes ☐ No	❒
48. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice medicine safely?	☐ Yes ☐ No	❒
49. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice medicine safely?	☐ Yes ☐ No	❒
50. Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?	☐ Yes ☐ No	❒
51. Do you suffer from a progressive disorder or a health condition that will likely result in a general decline in health or function that may impair or limit your ability to practice medicine safely?	☐ Yes ☐ No	❒

NOTE: A "yes" response to question 42-51 requires a signed and dated written explanation. The *Explanation For Application Question* form may be used to provide your explanation.

L1E

PHOTOGRAPH

MBC Use Only

Rev L1A-F Staff Initials & Date

Photograph
Affix a 2" X 2" Photo Here
Photo Must Be Recent and Must Be of your Head and Shoulder Areas Only
Altered Photographs are NOT Acceptable

Notice: All items in this application are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensing per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

Photograph ❒

DECLARATION

Applicant Name & DOB ❒

The applicant, _____, _____,
PRINT LEGAL NAME (First, Middle, Last, Suffix) **DATE OF BIRTH (mm/dd/yyyy)**

being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

Applicant Signature & Date ❒

SIGN LEGAL NAME:_____DATE:_____

NOTARY SECTION

Applicant Signature ❒

SIGNATURE OF APPLICANT: _____
(SIGN LEGAL 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_____,

Applicant Name & Notary Date ❒

by, _____ proved to me on the basis of satisfactory evidence
(PRINT APPLICANT'S LEGAL NAME)

to be the person who appeared before me.

NOTARY SEAL

Notary Signature & Seal ❒

_____
SIGNATURE OF NOTARY PUBLIC

L1F