



MEDICAL BOARD OF CALIFORNIA

Licensing Program



APPLICATION

TYPE OF APPLICATION						MBC Use Only
(Check One)		(Check All That Apply)				Application Type <input type="checkbox"/>
U.S. or Canadian Medical School Graduate International Medical School Graduate		Physician's and Surgeon's License Postgraduate Training Authorization Letter (PTAL) Update Application: File # _____ Limited Practice License				
PRIORITY REVIEW & EXPEDITED LICENSURE						Priority Review <input type="checkbox"/>
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.						
PERSONAL INFORMATION						Legal Name <input type="checkbox"/> SSN/ITIN <input type="checkbox"/> DOB Gender <input type="checkbox"/> <input type="checkbox"/> Address of Record <input type="checkbox"/> Confidential Address <input type="checkbox"/> Telephone Numbers <input type="checkbox"/> Email <input type="checkbox"/> Military <input type="checkbox"/> <input type="checkbox"/>
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	
6. Address of Record	Mailing Address (40 characters maximum per line, including spaces)					
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 continued (40 characters maximum per line, including spaces)					
	City	State/Province		Zip/Postal Code	Country	
Confidential Address (Only required if Address of Record is a P.O. Box)						
7. Telephone Numbers	Home #	Work #		Cell #		
8. E-mail Address (Required)						
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
MBC Use Only	Cashiering	Pathway		School Code		L1A

APPLICANT: (Print Legal Name)	DATE OF BIRTH: (mm/dd/yyyy)	MBC Use Only <input type="checkbox"/> 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	Previous App/License <input type="checkbox"/>	
12. Have you previously held a Physician's and Surgeon's License in California? If yes, please provide license number: _____ Expired: _____	Yes No	<input type="checkbox"/>	
EXAMINATIONS			
13. Are you certified by the Educational Commission for Foreign Medical Graduates?	Yes No	ECFMG <input type="checkbox"/>	
14. List all of the following examinations you have taken and passed: USMLE, FLEX, NBME, LMCC and/or STATE BOARDS			
Examination	Date Passed		
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
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 School Name	Mailing Address	Dates of Attendance (mm/dd/yyyy)	
		Start	
		End	
		Start	
		End	
		Start	
		End	
Medical School of Graduation	Title of Degree Awarded	Issue Date of Degree (mm/dd/yyyy)	

MBC Use Only

Name & DOB

Previous App/License

ECFMG

Exams

Medical Education

School Code

L2 Trans

School Code

Diploma

L1B

APPLICANT: (Print Legal Name)	DATE OF BIRTH: (mm/dd/yyyy)	MBC Use Only <input type="checkbox"/> Name & DOB <input type="checkbox"/> PG Training Programs
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 <input type="checkbox"/>
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 <input type="checkbox"/>
18. Have you ever taken a leave of absence or break from your training?		Yes No <input type="checkbox"/>
19. Have you ever been terminated, dismissed or expelled from a program?		Yes No <input type="checkbox"/>
20. Have you ever been placed on probation for any reason?		Yes No <input type="checkbox"/>
21. Have you ever been disciplined or placed under investigation?		Yes No <input type="checkbox"/>
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 <input type="checkbox"/>
23. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?		Yes No <input type="checkbox"/>
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 <input type="checkbox"/>
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 <input type="checkbox"/> Name & DOB
ABMS CERTIFICATION		
25. Are you currently certified by a Member Board of the American Board of Medical Specialties?	Yes No	ABMS <input type="checkbox"/>
MALPRACTICE HISTORY		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	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
29. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?	Yes No	<input type="checkbox"/>
30. Have you ever been denied a license to practice medicine?	Yes No	<input type="checkbox"/>
31. Is any denial pending against you?	Yes No	<input type="checkbox"/>
32. Have you ever had any license to practice medicine subjected to any disciplinary action?	Yes No	<input type="checkbox"/>
33. Is any disciplinary action pending against any of your licenses to practice medicine?	Yes No	<input type="checkbox"/>
34. Have you ever surrendered a license to practice medicine?	Yes No	<input type="checkbox"/>
35. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	Yes No	<input type="checkbox"/>
36. Have you ever had any license to practice medicine subjected to any action including, <i>but not limited to</i> , informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?	Yes No	<input type="checkbox"/>
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	<input type="checkbox"/>
38. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	Yes No	<input type="checkbox"/>
39. Is any disciplinary action pending against your hospital or staff privileges?	Yes No	<input type="checkbox"/>
40. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	Yes No	<input type="checkbox"/>
41. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?	Yes No	<input type="checkbox"/>
NOTE: A “yes” response to question 26-41 requires a signed and dated written explanation. The <i>Explanation For Application Question</i> form may be used to provide your explanation.		L1D

APPLICANT: (Print Legal Name)	DATE OF BIRTH: (mm/dd/yyyy)	MBC Use Only <input type="checkbox"/> 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.		
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? <i>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.</i>	Yes No	<input type="checkbox"/>
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	<input type="checkbox"/>
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	<input type="checkbox"/>
45. Are you a registered sex offender?	Yes No	<input type="checkbox"/>
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 <i>Application Information for a Limited Practice License</i> for further information.		
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	<input type="checkbox"/>
47. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?	Yes No	<input type="checkbox"/>
48. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice medicine safely?	Yes No	<input type="checkbox"/>
49. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice medicine safely?	Yes No	<input type="checkbox"/>
50. Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?	Yes No	<input type="checkbox"/>
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	<input type="checkbox"/>
NOTE: A “yes” response to question 42-51 requires a signed and dated written explanation. The <i>Explanation For Application Question</i> form may be used to provide your explanation.		

L1E

PHOTOGRAPH

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.

MBC
Use Only

Rev L1A-F

Staff Initials
& Date

Photograph

Applicant
Name & DOB

DECLARATION

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.

SIGN LEGAL NAME: _____ **DATE:** _____

Applicant
Signature
& Date

NOTARY SECTION

SIGNATURE OF APPLICANT: _____
(SIGN LEGAL NAME IN THE PRESENCE OF NOTARY)

Applicant
Signature

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 APPLICANT'S LEGAL NAME)

to be the person who appeared before me.

NOTARY SEAL

Applicant
Name &
Notary Date

Notary
Signature
& Seal

SIGNATURE OF NOTARY PUBLIC

L1F