



# MEDICAL BOARD OF CALIFORNIA

Protecting consumers by advancing high quality, safe medical care.

**Licensing Program**  
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Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

## CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

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

Type or Print Legibly				APPLICANT INFORMATION		MBC Use Only		
<b>LEGAL NAME:</b>		Last	First	Middle	Suffix			
<b>Date of Birth</b> (mm/dd/yyyy)	<b>Last 4 Digits of U.S. SSN or ITIN</b>		<b>Medical School of Graduation</b>				Applicant Information <input type="checkbox"/>	
<b>PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION</b>								
<b>Facility Name</b>								Verified Program Information <input type="checkbox"/>
<b>Facility Address</b>								
<b>Specialty</b>			<b>ACGME 10-digit Program #</b> <a href="https://apps.acgme.org/ads/Public">https://apps.acgme.org/ads/Public</a>				<input type="checkbox"/>	
<b>Dates of Training</b> (mm/dd/yyyy)	Start Date:		End Date (or anticipated completion date):					
<b>UNUSUAL CIRCUMSTANCES</b>								
<i>Program Director: Please provide a signed and dated letter of explanation, including dates, for any "yes" response to questions # 1-7. The explanation must be provided on program letterhead and mailed directly to the Board with the Form L3A-L3B.</i>								
1. Did the applicant receive partial or no credit during his/her postgraduate training?				Yes	No	<input type="checkbox"/>		
2. Did the applicant ever take a leave of absence or break from his/her training?				Yes	No	<input type="checkbox"/>		
3. Was the applicant ever terminated, dismissed or expelled?				Yes	No	<input type="checkbox"/>		
4. Was the applicant ever placed on probation?				Yes	No	<input type="checkbox"/>		
5. Was the applicant ever disciplined or placed under investigation?				Yes	No	<input type="checkbox"/>		
6. Were any limitations or special requirements placed upon the applicant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?				Yes	No	<input type="checkbox"/>		
7. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year?				Yes	No	<input type="checkbox"/>		
<b>GENERAL MEDICINE TRAINING REQUIREMENT</b>								
8. Did the applicant complete a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC?				Yes	No	<input type="checkbox"/>		
To qualify for licensure in California, applicants who are graduates of an international medical school must complete <b>at least four (4) months</b> of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete <b>four (4) months</b> of training in GENERAL MEDICINE prior to licensure. <i>The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant had direct patient care responsibilities for at least four months in any particular specialty or sub-specialty area.</i>								
<b>L3A</b>								

## APPLICANT INFORMATION

LEGAL NAME: Last First Middle Suffix

MBC  
Use Only

Applicant's  
Name

### ATTENTION: PROGRAM DIRECTOR

Do not sign and date this form prior to the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the applicant has satisfactorily completed a period of accredited postgraduate training at this facility and that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

THE PERSON WHO SIGNS THIS FORM MAY NOT 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.

### PROGRAM DIRECTOR OFFICIAL CERTIFICATION

The program director signing this form is formally certifying and documenting under penalty of perjury that the applicant received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to satisfactory performance. The program director is attesting to the fact that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

*I hereby declare under penalty of perjury under the laws of the State of California that all of the information contained on these forms 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 completed by the applicant named on the Form L3A, and the applicant was trained in an ACGME or RCPSC slotted program position.*

Verified  
PD  
Staff  
Initials &  
Date

\_\_\_\_\_  
PRINTED NAME OF PROGRAM DIRECTOR

\_\_\_\_\_  
SIGNATURE OF PROGRAM DIRECTOR

(Signature Stamp Is Not Acceptable)

\_\_\_\_\_  
DATE

Program  
Director's  
Signature &  
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.

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

HOSPITAL or NOTARY SEAL

Program  
Director's  
Signature

Notary  
Signature &  
Seal

Hospital Seal

**L3B**

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