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

# LICENSE INFORMATION FOR INTERNATIONAL MEDICAL SCHOOL GRADUATES

## MINIMUM REQUIREMENTS TO APPLY FOR A LICENSE

- To be eligible for a Physician's and Surgeon's license, applicants must have received all of their medical school education from and graduated from a medical school recognized or approved by the Medical Board of California (Board). The medical school's name must exactly match the name on the Board's list of recognized 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. Prior to submitting an application, please refer to the Board's website to verify your medical school is recognized:

  http://www.mbc.ca.gov/Applicants/Medical_Schools/Schools_Recognized.aspx

- Disclosure of your United States Social Security Number (SSN) or your Individual Taxpayer Identification Number (ITIN) is mandatory prior to the issuance of a license. Section 30 of the Business and Professions Code authorizes collection of your SSN or ITIN. Section 31(e) of the Business and Professions Code allows the State Board of Equalization and the Franchise Tax Board to share taxpayer information with the Board. A license issued by the Board may be suspended if a state tax obligation is not paid. *Reporting a number on your Application that is not your SSN or ITIN may be grounds for denial of licensure.*
- To meet the examination requirement, you must have taken and passed all steps of the USMLE or other acceptable examinations per Section 1328 of Title 16 California Code of Regulations. Please refer to our website to obtain a copy of Section 1328 for a listing of all acceptable examinations.
- To meet the postgraduate training requirement, you must have satisfactorily completed a minimum of two (2) years of ACGME and/or RCPSC accredited postgraduate training (RCPSC training must be completed in Canada) that includes at least four months of postgraduate training in general medicine. The second year of postgraduate training must consist of 12-continuous months of training within the same program.

## GENERAL INFORMATION

- As an applicant, you personally are responsible for all information disclosed on your Application, Forms L1A-L1F, including any responses that may have been completed on your behalf by others. An application may be denied based upon omission, falsification or misrepresentation of any item or response on the application or any attachment. The Medical Board of California considers violations of an ethical nature to be a serious breach of professional conduct.
- **Processing Times:** Application materials are processed in the date order in which the application is received. All application forms and supporting materials are stamped with the date and time received in the office. Generally, you should anticipate receiving written correspondence confirming the status of the application for licensure within 60 days of submission of the application.

## GENERAL INFORMATION (CONTINUED)

- **FCVS**: The Federation Credentials Verification Service (FCVS) is operated by the Federation of State Medical Boards of the United States, Inc. The Medical Board of California (Board) offers this link to FCVS as a convenience to our applicants. You may learn more about FCVS at: http://www.fsmb.org/licensure/fcvs/.

  *The Board does not mandate that you use the FCVS.* FCVS is NOT a requirement for filing a Physician's and Surgeon's Application. You will be required to complete the Board's application and provide all necessary supporting documentation. As part of your application, you may request FCVS to submit directly to the Board your *Medical Professional Information Profile.* We will review the information provided along with our application and determine on an individual basis the items that we will accept from FCVS.

- **NotaryCam**: NotaryCam is a company that provides an online notary service that is valid in California and may be used on our Application forms. *The Board does not mandate that you use this online service.* The Board is providing this information as a convenience to its applicants. You may obtain further information regarding this online notary service at: https://www.notarycam.com/.

- **Certified Electronic Diploma (CeDiploma™):** CeDiploma Trust is a company that provides an alternative to a paper diploma and is accepted by the Medical Board of California. *The Board does not mandate that you use this online service.* If you were not issued a CeDiploma™ by your medical school, please contact your school directly. The Board is providing this information as a convenience to its applicants. You may obtain further information regarding this electronic diploma service at the following website: https://www.cediplomatrust.com.

- **Fingerprints**: Applicants who reside in California must complete the electronic *Live Scan* fingerprint process. You will need to use the *Request for Live Scan Service* form that may be obtained from the Board's website. Please refer to the following website for Live Scan facilities in California: http://ag.ca.gov/fingerprints/publications/contact.php.

  Applicants residing outside California must submit two completed fingerprint cards or have your fingerprints completed at a California Live Scan facility.

  *Criminal Records Check from both the California Department of Justice and the Federal Bureau of Investigation must be received prior to the issuance of a Physician's and Surgeon's license.*

- **Convictions**: Note that convictions adjudicated in juvenile courts or convictions two years or older under Health and Safety Code sections 11357(b), (c), (d), (e) or section 11360(b) need not be reported. Convictions expunged or set aside pursuant to section 1203.4 of the California Penal Code or equivalent non-California law MUST be disclosed. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction (see the Criminal Record History section on the Application).

- **Grounds for Denial**: Each applicant's credentials for licensure in California are reviewed on an individual basis. The Board has the authority to deny licensure based upon an applicant's act of dishonesty, unprofessional conduct, conviction of a crime, discipline of another state license, or inability to practice medicine safely.

- **Due Diligence**: Pursuant to Section 1306 of Title 16 California Code of Regulations, an application shall be deemed abandoned if an applicant fails to complete the application process within 365 days from the date of written notification from the Board of the documents needed to complete the application.

| LICENSE APPLICATION CHECKLIST | |
|---|---|
| **Listed below are the minimum application and supporting materials required for an international medical school graduate to obtain a Physician's and Surgeon's license. This list is not all-inclusive as additional items may be necessary based on responses provided on your *Application* or information obtained from other entities.** | |
| **Application, Fees, and Fingerprints** | |
| ☐ **Application Fee $491** | The Application fee is non-refundable. Refer to the *Fee Schedule* for further details. |
| ☐ **Initial License Fee $808.00 *or* Reduced Initial License Fee $416.50** | Refer to the *Fee Schedule* for further details. |
| ☐ **Application For Physician's and Surgeon's License, Forms L1A-L1F** | Complete all fields, answer all questions and have the application notarized. All six pages must be submitted together. |
| ☐ **Fingerprints:**<br><br>**Live Scan Form (CA Only)**<br>***or***<br>**Two (2) Fingerprint Cards** | Applicants who reside in California must complete the electronic *Live Scan* fingerprint process. You will need to use the *Request for Live Scan Service* form that may be obtained from the Board's website. Mail a copy of the completed form with your Application.<br><br>Applicants residing outside California must submit two completed fingerprint cards or have your fingerprints completed at a California Live Scan facility. Fingerprint cards will be mailed to you once the Board receives your application and appropriate processing fees. All personal data must be completed on the fingerprint cards or the cards will be returned for completion.<br><br>*Criminal Records Check from both the California Department of Justice and the Federal Bureau of Investigation must be received prior to the issuance of a Physician's and Surgeon's license.* |
| **Examination Documentation** | |
| ☐ **ECFMG Certification Status Report** | A Certification Status Report from the Educational Council for Foreign Medical Graduates (ECFMG) is required to verify your certification is valid. The ECFMG Certification Status Report may not be required if you have held a full and unrestricted license for four or more years in the U.S. or Canada since completion of postgraduate training. You may obtain further information from their website at www.ecfmg.org. ***The ECFMG must mail the Certification Status Report directly to the Board to be acceptable.*** |
| ☐ **Official Examination Scores from the appropriate examination entity: USMLE, FLEX, NBME, LMCC and State Boards** | Official examination history reports must be requested from the appropriate examination agency. ***Each examination agency must submit an original, official examination history report directly to the Board to be acceptable.*** Official examination history reports may be requested from the following websites:<br><br>USMLE, FLEX - *www.fsmb.org*<br>NBME - *www.nbme.org*<br>LMCC (Canada) - *www.mcc.ca*<br><br>*Refer to California Code of Regulations, Section 1328, for a list of acceptable examinations.* |

| Medical Education Documentation | |
|---|---|
| ☐ **Certificate of Medical Education, Form L2** | A Certificate of Medical Education, Form L2, is required from each medical school attended. Complete the applicant information at the top of the form and mail it to your medical school. The form will need to be completed, signed and dated by the school official and affixed with the official medical school seal. Any fields or questions left unanswered will require completion of a new form. ***The Form L2 must be mailed directly from the medical school to the Board to be acceptable.*** |
| ☐ **Official Medical School Transcript** | An original official medical school transcript and translation (if not in English), prepared on university letterhead affixed with the signature of the dean or registrar and the medical school seal, documenting all of the basic science and clinical courses completed during the medical curriculum is required. A transcript is required from each medical school attended. ***The transcript must be mailed directly from the medical school to the Board to be acceptable.*** |
| ☐ **Certified Copy of Medical School Diploma** | A certified copy of your medical school diploma is required. The certified copy must have the original signature of the dean or registrar of the medical school, be affixed with the official medical school seal, and include a statement attesting that the copy is a true and correct copy of the original. ***The certified copy of your diploma must be mailed directly from the medical school to the Board to be acceptable.*** |
| ☐ **Certificate of Clinical Training, Form L5** | A Certificate of Clinical Training, Form L5, is required to report <u>all</u> undergraduate clinical clerkships. Complete the applicant information at the top of the form and mail it to your medical school. The form will need to be completed, signed and dated by the school official and affixed with the official medical school seal. You may print or copy as many forms as necessary to provide a complete breakdown of your undergraduate clinical training. ***The Form(s) L5 must be mailed directly from the medical school to the Board to be acceptable.***<br><br>For your information, the pertinent portions of Section 2089.5 of the Business and Professions Code require:<br><br>"(b) Instruction in the clinical courses shall total a minimum of 72 weeks in length.<br>(c) Instruction in the core clinical courses of surgery, medicine, family medicine, pediatrics, obstetrics and gynecology, and psychiatry shall total a minimum of 40 weeks in length with a minimum of eight weeks instruction in surgery, eight weeks in medicine, six weeks in pediatrics, six weeks in obstetrics and gynecology, a minimum of four weeks in family medicine, and four weeks in psychiatry."<br><br>Please refer to our website at www.mbc.ca.gov to obtain a complete copy of Section 2089.5 of the Business and Professions Code. |

| **Medical Education Documentation** (continued) | |
|---|---|
| ☐ **Certificate of Individual Clinical Clerkship Training, Form L6** *(if applicable)* | Certificate of Individual Clinical Clerkship Training, Form L6, is required for <u>each</u> undergraduate clinical clerkship completed o***utside*** of the primary teaching hospital of the medical school of attendance. The form must be submitted to the hospital where the clerkship was completed and the current program director or clinical instructor must verify completion of the clerkship. The form may not be signed and dated prior to the end date of the clerkship. ***The completed Form(s) L6 must be submitted directly from the facility to the Board to be acceptable.***<br><br>If the hospital where an undergraduate clinical rotation was completed is now closed, the medical school may provide a certified copy of the student evaluation form that was initially completed by the sponsoring hospital. The copy must be affixed with the medical school seal and signature of the dean certifying it is a true copy of the original document and mailed directly to the Board.<br><br>For your information, only undergraduate clinical clerkships meeting the criteria specified in Section 2089.5 of the Business and Professions Code will be used to satisfy the required 72 weeks of clinical clerkships. |
| ☐ **Certified English Translations** *(if applicable)* | Certified English translations are required for all academic documents that are not prepared in the English language. Refer to the *Translation of International Academic Credentials* for details regarding acceptable translations. ***The certified translation must be mailed directly to the Board to be acceptable.*** |
| **Postgraduate Training Documentation** | |
| ☐ **Certificate of Completion of ACGME/RCPSC Postgraduate Training, Forms L3A-L3B** | A Certificate of Completion of ACGME/RCPSC Postgraduate Training, Form L3A-L3B, is required to verify the completion of each year of accredited training. The form may not be signed and dated prior to the last day of the training year that will be used to meet the two years of ACGME or RCPSC accredited postgraduate training required for licensure.<br><br>A Form L3A-L3B must be submitted to each postgraduate training program for completion. The current program director must provide all of the required information and responses on the form, sign and date the form, and affix the hospital seal. If a hospital seal is not available, the program director must sign in the presence of a notary and the notary seal must be affixed. A "yes" response to any of the Unusual Circumstances questions on Form L3A requires a signed and dated letter of explanation from the current program director. ***The completed Form L3A-L3B must be mailed directly from the program to the Board to be acceptable. Any letters of explanation must be provided on program letterhead, signed by the program director and mailed directly to the Board.***<br><br>Please be advised, Section 2066 of the Business and Professions Code allows graduates of international medical schools to engage in three years of ACGME accredited postgraduate training without a license. In calculating the maximum three years of training, the Board includes all approved training completed in the U.S. and Canada whether or not any credit was granted. At the end of the three-year period, you must be licensed or all clinical activities in California facilities must cease. |

| **Postgraduate Training Documentation** (continued) | |
|---|---|
| ☐ **Current Postgraduate Training Enrollment, Form L4** *(if applicable)* | If you are enrolled in an accredited training program at the time of application, this form is necessary to be eligible for the reduced initial licensing fee. Complete the top section and submit the form to your current training program for completion. The current program director must provide all of the required information and responses on the form, sign and date the form, and affix with the hospital seal. If a hospital seal is not available, the program director must sign in the presence of a notary and the notary seal must be affixed. ***The completed Form L4 must be mailed directly from the program to the Board to be acceptable.*** |
| **Verification of Medical License(s)** | |
| ☐ **License Verification** *(if applicable)* | License verification is required from <u>each</u> state or Canadian province in which you hold or have held a medical license. Verification of temporary, training, or provisional license(s) are <u>not</u> required. ***The official license verification must be sent directly from the licensing authority to the Board.*** |
| **Other Items** | |
| ☐ **Curriculum Vitae (CV)** | Please submit a signed and dated current CV with your Application. |
| ☐ **Timeline of Activities** | A complete timeline from the graduation of medical school to present is required. Provide the Board with a written chronological description of all your professional and non-professional activities with no gaps.<br><br>If you have completed any externships, observerships, or volunteer activities in California, please include a detailed description of your duties and responsibilities along with the location and name of the supervising physician.<br><br>Mail your signed and dated *Timeline of Activities* form directly to the Board. |
| ☐ **Explanation to Application Question** *(if applicable)* | This form may be used to provide a detailed written explanation for a "yes" response to a question on the Application. Please use a separate form for each positive response. The form can be obtained from the Board's website. |

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# FEE SCHEDULE

## Application for Physician's and Surgeon's License
## or
## Postgraduate Training Authorization Letter (PTAL)

| | | | |
|---|---|---|---|
| **PART 1: APPLICATION FEE** | | | |
| The application fee includes a required fingerprint processing fee. Please note, the application will not be reviewed until the required application fee is received. | | | |
| **Total Non-Refundable Application Fee** | **Required** → | | **$ 491.00** |
| **PART 2: LICENSE FEE** | | | |
| **License fees are required prior to issuance of your medical license.**<br>To reduce delays in issuing a license, you may submit the application and license fees together.<br>**Initial License Fee ($808.00) or Reduced Initial License Fee ($416.50)** – If you currently are enrolled in an ACGME/RCPSC accredited training program, you may be eligible for the reduced initial licensing fee. To verify your enrollment, you will need to submit a Certificate of Current Postgraduate Training, Form L4.<br>The license fee includes a mandatory $25 fee for the Steven M. Thompson Physician Corps Loan Repayment Program.<br>**NOTE:** PTAL applicants are not required to submit the initial license fees until all licensing requirements have been met. | | | |
| **Initial License Fee**<br>**or**<br>**Reduced Initial License Fee** | **Required Prior to Licensure** | **$808.00 or $416.50** | |
| **PART 3: SONG-BROWN FAMILY PHYSICIAN TRAINING ACT** | | | |
| The Song-Brown Health Care Workforce Training Act (Song-Brown Program) was established to increase the number of family physicians to provide needed medical services to the people of California. The program encourages universities and primary care health professionals to provide healthcare in medically underserved areas, and provides financial support to family medicine, internal medicine, OB/GYN, and pediatric residency programs, family nurse practitioner, physician assistant, and registered nurse education programs throughout California. For further information regarding the program, please visit the Office of Statewide Health Planning and Development (OSHPD) website at http://www.oshpd.ca.gov/hwdd/Song_Brown_Prog.html. | | | |
| You may voluntarily contribute any amount (minimum $25.00) to the Song-Brown Program. The Board transfers all funds collected on a monthly basis to OSHPD. | **Voluntary** | **$25.00** (minimum) | |
| **PART 4: TOTAL AMOUNT** | | | **$ 491.00** |

Certified Check, Cashier's Check, Money Order, or Personal Check made payable to:

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# LIVE SCAN INFORMATION

California's Department of Justice (DOJ) provides statewide Live Scan, which is an electronic fingerprinting system with a subsequent automated background check and response. This system significantly expedites the fingerprint clearance process. **APPLICANTS WHO RESIDE IN CALIFORNIA MUST COMPLETE THE ELECTRONIC LIVE SCAN FINGERPRINT PROCESS.** Applicants residing outside of California may choose this option if visiting the state.

**• CALIFORNIA DOES NOT HAVE LIVE SCAN LINKS TO ANY OTHER STATES •**

The "Request For Live Scan Service" form (below) is required to have your fingerprints processed by Live Scan. This form must be completed in triplicate; therefore, THREE copies will be printed automatically when printing the form. Please ensure that all personal data (name, AKA's, date of birth, sex, height, weight, eye color, hair color, place of birth, Social Security Number or Individual Taxpayer Identification Number, California driver's license number and home address) is provided on *each of the three forms*. The last section of the form requires information from the fingerprint agency; please ensure this information is completed or the forms will be void. **It is the responsibility of the applicant to ensure that the person scanning the fingerprints submits TWO digital prints, one for the DOJ and one for the FBI.**

Applicants can access the website, **http://ag.ca.gov/fingerprints/publications/contact.htm** to obtain the names and location of approved fingerprint sites. Information pertaining to the need for appointments, hours of availability, and rolling fees are also available through that website. **After completing the Live Scan process, applicants must submit ONE of the THREE forms with the initial application to document the scanning of their fingerprints.** The results of Live Scan fingerprints are generally received within five (5) days.

Applicants residing outside of California must submit two completed fingerprint cards or have your fingerprints completed at a California Live Scan facility. The results of paper fingerprint cards are generally received within six (6) weeks.

Whether you use Live Scan or paper fingerprint cards, you will be charged an administrative fee by the local agency that scans the prints or provides the inked impressions. This is in addition to the fingerprint processing fee that must be paid to the Medical Board of California with your application. For further information about the fingerprint clearance process and time frames, please visit the following website at: **http://ag.ca.gov/consumers/morefaqs.php**

Because applicants from the medical professions must be concerned with sanitary issues, they wash and scrub their hands so much that images of their fingerprints are often difficult to read. When the impressions are of such poor quality that they cannot be searched in DOJ's fingerprint data base, the fingerprints (whether Live Scan or paper card) are rejected and reprints will be necessary. Therefore, please advise the person processing your fingerprints that extra care needs to be given to ensure that clear impressions have been made.

**Criminal Records Check from both the California Department of Justice and the Federal Bureau of Investigation must be received prior to the issuance of a Postgraduate Training Authorization Letter (PTAL) or a Physician's and Surgeon's medical license.**

**NOTE: If you have ever been convicted of a misdemeanor or felony, the record of conviction will be reported to the Board as a result of your fingerprint inquiry.**

STATE OF CALIFORNIA
BCIA 8016
(orig. 04/2001; rev. 01/2011)

DEPARTMENT OF JUSTICE

# REQUEST FOR LIVE SCAN SERVICE

*Applicant Submission*

A0383
ORI (Code assigned by DOJ)

LICENSE, CERTIFICATION, PERMIT
Authorized Applicant Type

PHYSICIAN & SURGEON
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

MEDICAL BOARD OF CALIFORNIA
Agency Authorized to Receive Criminal Record Information

05612
Mail Code (five-digit code assigned by DOJ)

2005 EVERGREEN STREET, SUITE 1200
Street Address or P.O. Box

TONYA MORAIRTY
Contact Name (mandatory for all school submissions)

SACRAMENTO
City

CA
State

95815
ZIP Code

(916) 561-8255
Contact Telephone Number

Applicant Information:

Last Name

First Name

Middle Initial

Suffix

Other Name (AKA or Alias) Last

First

Suffix

Date of Birth

Sex ☐ Male ☐ Female

Driver's License Number

Height

Weight

Eye Color

Hair Color

Billing Number 130065
(Agency Billing Number)

Place of Birth (State or Country)

Social Security Number

Misc. Number
(Other Identification Number)

Home Address Street Address or P.O. Box

City

State

ZIP Code

Your Number:
OCA Number (Agency Identifying Number)

Level of Service: ☒ DOJ ☒ FBI

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

Employer Name

Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City

State

ZIP Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

LSID

ATI Number

Amount Collected/Billed

ORIGINAL - Live Scan Operator

SECOND COPY - Applicant

THIRD COPY (if needed) - Requesting Agency

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BCIA 8016
(orig. 04/2001; rev. 01/2011)

DEPARTMENT OF JUSTICE

# REQUEST FOR LIVE SCAN SERVICE

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LICENSE, CERTIFICATION, PERMIT
Authorized Applicant Type

PHYSICIAN & SURGEON
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

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State

95815
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(916) 561-8255
Contact Telephone Number

Applicant Information:

Last Name

First Name

Middle Initial

Suffix

Other Name (AKA or Alias) Last

First

Suffix

Date of Birth

Sex ☐ Male ☐ Female

Driver's License Number

Height

Weight

Eye Color

Hair Color

Billing Number 130065
(Agency Billing Number)

Place of Birth (State or Country)

Social Security Number

Misc. Number
(Other Identification Number)

Home Address Street Address or P.O. Box

City

State

ZIP Code

Your Number:
OCA Number (Agency Identifying Number)

Level of Service: ☒ DOJ ☒ FBI

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

Employer Name

Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City

State

ZIP Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

LSID

ATI Number

Amount Collected/Billed

ORIGINAL - Live Scan Operator

SECOND COPY - Applicant

THIRD COPY (if needed) - Requesting Agency

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DEPARTMENT OF JUSTICE

# REQUEST FOR LIVE SCAN SERVICE

*Applicant Submission*

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ORI (Code assigned by DOJ)

LICENSE, CERTIFICATION, PERMIT
Authorized Applicant Type

PHYSICIAN & SURGEON
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

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Contact Telephone Number

Applicant Information:

Last Name

First Name

Middle Initial

Suffix

Other Name (AKA or Alias) Last

First

Suffix

Date of Birth

Sex ☐ Male ☐ Female

Driver's License Number

Height

Weight

Eye Color

Hair Color

Billing Number 130065
(Agency Billing Number)

Place of Birth (State or Country)

Social Security Number

Misc. Number
(Other Identification Number)

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State

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Your Number:
OCA Number (Agency Identifying Number)

Level of Service: ☒ DOJ ☒ FBI

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

Employer Name

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Street Address or P.O. Box

City

State

ZIP Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

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# TRANSLATION OF INTERNATIONAL ACADEMIC CREDENTIALS

For the Board to accurately evaluate compliance with California requirements, any applicant with non-English, international academic credentials must provide certified translations of those original transcripts and academic documents. These must be original, official certified translations. **Photocopies are not acceptable.** When requesting official transcripts and academic documents, an applicant whose education was completed at an institution in a bilingual country, where English is one of the official languages, may be able to avoid the necessity of arranging for a translation by asking the school to generate an English-language version of the transcript.

Applicants may also request their medical school to provide original, official, literal word-for-word, certified translations of their official transcripts and academic documents. The Board will consider medical school translations prepared on the official school letterhead with the translator's original declaration, and the translator's signature and title.

- **Each translator must provide an original signed declaration with each translation attesting to his/her fluency in the particular language and certifying under penalty of perjury that the translation is complete and accurate to the best of the translator's ability and knowledge. Each translation must be accompanied by a copy of the corresponding non-English document. The official certified translation must be mailed directly from the translator to the Board to be acceptable.**

- **Translators who prepare translations may not be related to an applicant by blood, marriage, or adoption. Translations that are signed on behalf of the official translator are not acceptable; the translator who prepares the translation must provide the signed declaration. Translations without an official letterhead will not be accepted.**

The Board recommends, but does not require, that applicants with non-English academic credentials use one of the following sources for translation:

**Translator accredited by the American Translators Association (ATA):** The ATA accredits individual translators by examination. Although accreditation is available only to individuals, ATA membership includes not only individuals but companies that employ accredited translators. The translator who prepares the translation must sign the translation and declaration in the presence of a Notary Public, unless the translation is a service provided by a known translation agency which affixes the document with its own official seal. ATA membership includes accredited translators residing in the U.S., Canada, Mexico, and overseas. Although the ATA does not make referrals, a listing of accredited translators and member companies is available through its website at http://www.atanet.org./. The ATA may be reached by phone at 703-683-6100 or by e-mail at ata@atanet.org.

1. **Certified or registered court interpreter:** Some state court systems offer examinations for certification or registration of court interpreters. In California, the Judicial Council is charged with these functions. Information on court interpreters is available through the Judicial Council at 415-865-4200. General information is available via its website, http://www.courts.ca.gov./. The Judicial Council has contracted with Cooperative Personnel Services (CPS) for examination and certification of Certified Administrative Hearing and Medical Interpreters. A master list of these interpreters is available at the CPS website, www.courts.ca.gov/3796.htm. The court interpreter must sign the translation and declaration in the presence of a Notary Public. Applicants residing outside California but within the United States may call the National Center for State Courts at 800-616-6164 for information on certification and registration of interpreters in other states.

Other authorized translators the Board will consider include: (1) a commercial translation agency with its own business letterhead and official agency seal or notary public seal; (2) the Chairman of the Department of Foreign or Classical Languages of a U.S. university (prepared on original school letterhead); or (3) a consulate of the U.S. Embassy with bilingual translators available.

**NOTE: The official certified translation must be mailed directly from the medical school or from the translator to the Board to be acceptable.**

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# 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 | Previous App/License ☐ |
| 12. Have you previously held a Physician's and Surgeon's License in California? If yes, please provide license number: _____ Expired: _____ | ☐Yes ☐No | ☐ |

## 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) | | L2 ☐ Trans ☐ School Code |
|---|---|---|---|---|
| | | Start | | |
| | | End | | |
| | | Start | | ☐ ☐ |
| | | End | | |
| | | Start | | ☐ ☐ |
| | | End | | |

| 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?<br>***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**

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# EXPLANATION FOR APPLICATION QUESTION

**This form may be used to provide a detailed written explanation for a "yes" response to a question on the Application. Please use as many forms as necessary to provide a detailed explanation. A separate form is to be used for each question.**

**Type or Print Legibly**

## PERSONAL INFORMATION

**LEGAL NAME:** Last First Middle Suffix

| Date of Birth (mm/dd/yyyy) | U.S. SSN or ITIN | Medical School of Graduation |
|---|---|---|
| | | |

## DETAILED WRITTEN EXPLANATION

**Application Question Number:** #_____ **(List corresponding question number from the Application)**

SIGN LEGAL NAME: _____ DATE: _____

**Applicant's signature and date are required.**

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# TIMELINE OF ACTIVITIES

**A complete timeline of activities from graduation of medical school to present is required.** Provide the Board with a written chronological description of all your professional and non-professional activities. Please include a detailed description of your duties and responsibilities for any externship, observership, or volunteer activity in California. Dates shall be reported in chronological order in month/year (mm/yyyy) format. *Please use as many forms as necessary to provide a complete timeline of activities.*

**Type or Print Legibly** **PERSONAL INFORMATION**

**LEGAL NAME:** Last First Middle Suffix

| Date of Birth (mm/dd/yyyy) | U.S. SSN or ITIN | Medical School of Graduation |
|---|---|---|
| | | |

| Start Date | End Date | Location (Provide Facility Name, Address, and Supervisor) | Activities | MBC Use Only |
|---|---|---|---|---|
| | | | | ❒ |
| | | | | ❒ |
| | | | | ❒ |
| | | | | ❒ |
| | | | | ❒ |

SIGN LEGAL NAME:_____ DATE:_____

**Applicant's signature and date are required.**

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# CERTIFICATE OF MEDICAL EDUCATION

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

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

## MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

**NOTE:** If the applicant had an accelerated or extended curriculum, withdrew from this institution, or was accepted with advanced standing, a letter of explanation from a school official is required. The letter must be on medical school letterhead, signed by a school official, and be mailed directly to the Board from the medical school.

1. Name of Medical School
2. State/Province/Country
3. The undersigned further certifies that the records of this institution show that the applicant attended in this institution _____ ***years*** of resident instruction, completing at least 4,000 hours, of which at least 80 percent actual attendance is required in the subjects set forth hereunder (Business and Professions Code Sections 2089, 2089.5, 2089.7, 2090, 2091.1, 2091.2).

| | | | |
|---|---|---|---|
| **Alcoholism and Chemical Dependency** | **Geriatric Medicine** | **Otolaryngology** | **Psychiatry** |
| **Anatomy** | **Histology** | **Pain Management and End-of-Life-Care**** | **Radiology, including Radiation Safety** |
| **Anesthesia** | **Human Sexuality** | **Pathology, Bacteriology, and Immunology** | **Spousal Partner Abuse Detection & Treatment***** |
| **Biochemistry** | **Medicine** | **Pediatrics** | |
| **Child Abuse Detection and Treatment** | **Neuroanatomy** | **Pharmacology** | **Surgery, including Orthopedic Surgery** |
| **Dermatology** | **Neurology** | **Physical Medicine** | **Therapeutics** |
| **Embryology** | **Obstetrics and Gynecology** | **Physiology** | **Tropical Medicine** |
| **Family Medicine*** | **Ophthalmology** | **Preventative Medicine, including Nutrition** | **Urology** |

***ONLY applicable to medical students who enrolled in medical school on or after May 1, 1998**
****ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000**
*****ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994**

4. Did the applicant withdraw or transfer from this medical school? ☐ Yes ☐ No
5. What is the standard duration of the curriculum at this institution? years
6. Date the applicant was enrolled in medical school? (mm/dd/yyyy)
7. Date the applicant was issued the diploma of Bachelor/Doctor of Medicine (mm/dd/yyyy)

## UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

**Any "Yes" response below requires a signed and dated letter of explanation by school official.**

8. Did this applicant ever take a leave of absence from his/her medical education? ☐ Yes ☐ No
9. Was this applicant ever placed on probation? ☐ Yes ☐ No
10. Was this applicant ever disciplined or placed under investigation? ☐ Yes ☐ No
11. Were any limitations or special requirements imposed on this applicant because of questions of academic or disciplinary problems, or for any other reason? ☐ Yes ☐ No

## MEDICAL SCHOOL OFFICIAL CERTIFICATION

**AFFIX MEDICAL SCHOOL SEAL**

*I certify that I am the President, Dean, or Registrar and 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 SCHOOL OFFICIAL** | **TITLE OF SCHOOL OFFICIAL**

**SIGNATURE OF SCHOOL OFFICIAL** | **DATE**

**Attention Medical School**: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the President, Dean, or Registrar may sign this form. If the signature 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.

**MBC Use Only**
Applicant Information ❒
Medical School Information
School Code
❒
❒
Rev. L2 Staff Initials & Date
❒
❒
❒
❒
Unusual Circumstances
❒
❒
❒
❒
School Seal ❒
Signature and Date ❒

**L2**

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

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# 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

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

**MBC Use Only**

Applicant Information ❒

## PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

| | | | |
|---|---|---|---|
| **Facility Name** | | | |
| **Facility Address** | | | |
| **Specialty** | | **ACGME 10-digit Program #** https://apps.acgme.org/ads/Public | |
| **Dates of Training** (mm/dd/yyyy) | Start Date: | End Date (or anticipated completion date): | |

Verified Program Information ❒

❒ ❒

## UNUSUAL CIRCUMSTANCES

Unusual Circumstance

***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.**

| | | |
|---|---|---|
| 1. Did the applicant receive partial or no credit during his/her postgraduate training? | ☐ Yes ☐ No | ❒ |
| 2. Did the applicant ever take a leave of absence or break from his/her training? | ☐ Yes ☐ No | ❒ |
| 3. Was the applicant ever terminated, dismissed or expelled? | ☐ Yes ☐ No | ❒ |
| 4. Was the applicant ever placed on probation? | ☐ Yes ☐ No | ❒ |
| 5. Was the applicant ever disciplined or placed under investigation? | ☐ Yes ☐ No | ❒ |
| 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 | ❒ |
| 7. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year? | ☐ Yes ☐ No | ❒ |

## GENERAL MEDICINE TRAINING REQUIREMENT

Gen Med Required

| | | |
|---|---|---|
| 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 | ❒ |

To qualify for licensure in California, applicants who are graduates of an international medical school must complete **at least four (4) months** 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 **four (4) months** of training in GENERAL MEDICINE prior to licensure. *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.*

**L3A**

## APPLICANT INFORMATION

**LEGAL NAME:** Last First Middle Suffix

## 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.*

_____
**PRINTED NAME OF PROGRAM DIRECTOR**

_____ _____
**SIGNATURE OF PROGRAM DIRECTOR** **DATE**
(Signature Stamp Is Not Acceptable)

**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**

**MBC Use Only**

Applicant's Name ❒

Verified PD Staff Initials & Date

Program Director's Signature & Date ❒

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.***

MEDICAL BOARD
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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

# CURRENT POSTGRADUATE TRAINING ENROLLMENT

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

**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 TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

| | | | |
|---|---|---|---|
| **Facility Name** | | | |
| **Facility Address** | | | |
| **Specialty** | | **ACGME 10-digit Program #** https://apps.acgme.org/ads/Public | |
| **Dates of Training** (mm/dd/yyyy) | Start Date: | Anticipated Completion Date: | |

## PROGRAM DIRECTOR OFFICIAL CERTIFICATION

**ATTENTION PROGRAM DIRECTOR**: 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.

*I hereby declare under penalty of perjury under the laws of the State of California that the information contained on this form 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 to the above named applicant and that the applicant is actively participating in a slotted position in an accredited ACGME or RCPSC postgraduate training program.*

_____
**PRINTED NAME OF PROGRAM DIRECTOR**

_____ _____
**SIGNATURE OF PROGRAM DIRECTOR** (Signature Stamp Is Not Acceptable) **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**

**MBC Use Only**

Applicant Information ❐

Verified Program Information ❐

Verified PD Staff Initials & Date

Program Director's Signature & Date ❐

Program Director's Signature ❐

Notary Signature & Seal ❐

Hospital Seal ❐

**L4**

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

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

# CERTIFICATE OF CLINICAL TRAINING

**(This form is only required of international medical school graduates)**

**Type or Print Legibly**

## APPLICANT INFORMATION

**LEGAL NAME:** Last | First | Middle | Suffix

| Date of Birth (m/dd/yyyy) | Last 4 Digits of U.S. SSN or ITIN | Medical School of Graduation |
|---|---|---|
| | | |

**MBC Use Only**
Applicant Information ❒

## MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

**Report undergraduate clinical clerkships in which the applicant participated in DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING**. *Please use as many forms as necessary to document ALL undergraduate clinical clerkships completed during enrollment in medical school.*

**Note:** Section 2089.5(c) of the Business and Professions Code requires that instruction in the clinical courses shall total a minimum of 72 weeks. Instruction in the core clinical courses shall total a minimum of 40 weeks in length with a minimum of **(8)** weeks of medicine, **(8)** weeks of surgery, **(6)** weeks of pediatrics, **(6)** weeks of ob/gyn, **(4)** weeks of psychiatry, and **(4)** weeks of family medicine. (Family Medicine is required for applicants who graduated after May 1, 1998)

Rev. L5 Staff Initials & Date

| Clinical Subject (List one subject per line) | Facility Name City/State/Province/Country | Dates of Attendance in Chronological Order (mm/dd/yyyy) | Weeks or Weekly Clinical Hours |
|---|---|---|---|
| | | Start:<br>End: | |
| | | Start:<br>End: | |
| | | Start:<br>End: | |
| | | Start:<br>End: | |
| | | Start:<br>End: | |
| | | Start:<br>End: | |

❒ ❒ ❒ ❒ ❒ ❒

## MEDICAL SCHOOL OFFICIAL CERTIFICATION

**AFFIX MEDICAL SCHOOL SEAL**

*I certify that I am the President, Dean, or Registrar and 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 SCHOOL OFFICIAL** _____ **TITLE OF SCHOOL OFFICIAL** _____

**SIGNATURE OF SCHOOL OFFICIAL** _____ **DATE** _____

**Attention Medical School**: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the President, Dean, or Registrar may sign this form. If the signature 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.

School Seal ❒
Signature and Date ❒

**L5**

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

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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.***