MEDICAL BOARD OF CALIFORNIA
Licensing Program

APPLICATION INFORMATION FOR A PREVIOUSLY LICENSED CALIFORNIA PHYSICIAN

MINIMUM REQUIREMENTS TO REAPPLY FOR LICENSURE

- In accordance with Section 2428 of the California Business and Professions Code, a physician whose California Physician's and Surgeon's license expired five or more years ago must reapply for licensure. If you voluntarily canceled your license, you must reapply regardless of the time period.
- Although Section 2428 allows you to undertake a re-application process that is significantly streamlined, you must meet all of the requirements as if you were applying for licensure for the first time.
- You must have completed at least two years of ACGME/RCPSC accredited postgraduate training or have completed one year of approved training and be certified by a specialty board approved by the American Board of Medical Specialties (ABMS).

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 in this office. 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 a medical license within 60 days of submission of 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.
- **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).

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2487 www.mbc.ca.gov

GENERAL INFORMATION

- **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 our applicants. You may obtain further information regarding this online notary service at: https://www.notarycam.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.

- **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.

APPLICATION INFORMATION

Listed below are the minimum application and supporting materials required to reapply for your 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.

Upon receipt of your application and fees, we will retrieve your previously imaged licensing record and determine what documents may be used to meet the current requirements. In the event our imaged records do not contain all of the documents that are currently required, you may be requested to submit additional documents.

Application, Fees, and Original Wall Certificate	
☐ **Application Fee of $491.00**	The Application fee is non-refundable. Refer to the *Fee Schedule* for further details.
☐ **Initial License Fee of $808.00**	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.
☐ **Original California Wall Certificate or Notarized Statement**	Return your original California wall certificate. If it has been lost or destroyed, you must submit a notarized statement indicating the reason you are unable to return the original.

Fingerprints		
☐	**Fingerprints:** **Live Scan Form (CA Only)** ***or*** **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. Applicants residing outside California must submit two completed fingerprint cards <u>or</u> 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. <u>All personal data must be completed on the fingerprint cards or the cards will be returned for completion.</u> *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.*
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 <u>each</u> year of accredited training. The Board may have verification of your accredited postgraduate training in your previously imaged licensing record, however, we may only have partial years of training, which would require completion of new forms. 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.***
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.
☐	**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.

Other Items (continued)		
☐	**Birth Month Licensure Request**	California licensing regulations specify that a license expires at 12 midnight on the last day of the birth month of the licensee during the second year of a two year term. If you are licensed in your birth month, your initial license will be valid for a full 24-month term. If you are licensed in a month other than your birth month, the term of your *initial license* will be less than 24-months. Complete the Birth Month Licensure Request form indicating your preference and submit the form directly to the Board.

MEDICAL BOARD OF CALIFORNIA
Licensing Program

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. To reduce delays in issuing a license, you may submit the application and license fees together. **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. The license fee includes a mandatory $25 fee for the Steven M. Thompson Physician Corps Loan Repayment Program. **NOTE:** PTAL applicants are not required to submit the initial license fees until all licensing requirements have been met.			
Initial License Fee **or** **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			**$**

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

MEDICAL BOARD OF CALIFORNIA

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2487 www.mbc.ca.gov

MEDICAL BOARD OF CALIFORNIA
Licensing Program

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.

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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 MATHEWS
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

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 MATHEWS
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

STATE OF CALIFORNIA
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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)

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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

MEDICAL BOARD OF CALIFORNIA
Licensing Program

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
Confidential Address (Only required if Address of Record is a P.O. Box)				
7. Telephone Numbers	Home #	Work #	Cell #	
8. E-mail Address (Required)				

Address of Record ☐ — Confidential Address ☐ — Telephone Numbers ☐ — Email ☐

9.	Have you served or are you currently serving in the military?	☐ Yes ☐ No	Military ☐
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

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2487 www.mbc.ca.gov

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

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

L1D

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

CRIMINAL RECORD HISTORY

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

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

Criminal History

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

PRACTICE IMPAIRMENT OR LIMITATIONS

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

Limitations

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

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

L1E

PHOTOGRAPH

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.

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:**_____

NOTARY SECTION

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_____,

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

_____
SIGNATURE OF NOTARY PUBLIC

MBC Use Only

Rev L1A-F

Staff Initials & Date

Photograph ❑

Applicant Name & DOB ❑

Applicant Signature & Date ❑

Applicant Signature ❑

Applicant Name & Notary Date ❑

Notary Signature & Seal ❑

L1F

MEDICAL BOARD OF CALIFORNIA
Licensing Program

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.

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2487 www.mbc.ca.gov

MEDICAL BOARD OF CALIFORNIA
Licensing Program

BIRTH MONTH LICENSURE REQUEST

California licensing regulations specify that a license expires at 12 midnight on the last day of the birth month of the licensee during the second year of a two year term. If you are licensed in your birth month, your initial license will be valid for a full 24-month term. If you are licensed in a month other than your birth month, the term of your *initial license* will be less than 24-months.

Please indicate your preference by checking one of the options listed below:

☐	**I would like to wait until my birth month of _____ to be licensed.**
☐	**I would like to be licensed as soon as my application is processed. I understand and acknowledge my *initial license* will be valid for less than a 24-month term.**

Print Legal Name: _____

File #: _____
(If Known)

Date of Birth: _____
(mm/dd/yyyy)

Sign Legal Name: _____ Date: _____

Please return the form using one of the following methods:

1. Submit the completed form with your initial application.
2. Fax the completed form to the Board at (916) 263-2487.
3. Mail the completed form to the address listed below.

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2487 www.mbc.ca.gov

MEDICAL BOARD OF CALIFORNIA
Licensing Program

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**
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**		Applicant Information ❑

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION				
Facility Name				
Facility Address				Verified Program Information ❑
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):		❑ ❑

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

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APPLICANT INFORMATION

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

MBC Use Only

Applicant's Name ❑

ATTENTION: PROGRAM DIRECTOR

<u>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.</u> 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 <u>MAY NOT</u> 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.

Verified PD Staff Initials & Date

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.

Program Director's Signature & Date ❑

_____
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.**

Program Director's Signature ❑

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 _____

Notary Signature & Seal ❑

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)

Hospital Seal ❑

to be the person who appeared before me.

HOSPITAL or NOTARY SEAL

_____
SIGNATURE OF NOTARY PUBLIC

L3B

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