



MEDICAL BOARD OF CALIFORNIA

Protecting consumers by advancing high quality, safe medical care.

Licensing Program
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 Sacramento, CA 95815-5401
 Phone: (916) 263-2382
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 www.mbc.ca.gov

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

CERTIFICATE OF MEDICAL EDUCATION

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	Applicant Information <input type="checkbox"/>																																
Date of Birth (mm/dd/yyyy)		Last 4 Digits of U.S. SSN or ITIN		Medical School of Graduation			Medical School Information <input type="checkbox"/>																															
MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE						School Code <input style="width: 100%; height: 20px;" type="text"/>																																
<p>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.</p>																																						
1. Name of Medical School						<input type="checkbox"/>																																
2. State/Province/Country																																						
<p>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).</p> <table style="width:100%; font-size: small;"> <tr> <td>Alcoholism and Chemical Dependency</td> <td>Geriatric Medicine</td> <td>Otolaryngology</td> <td>Psychiatry</td> </tr> <tr> <td>Anatomy</td> <td>Histology</td> <td>Pain Management and End-of-Life-Care**</td> <td>Radiology, including Radiation Safety</td> </tr> <tr> <td>Anesthesia</td> <td>Human Sexuality</td> <td>Pathology, Bacteriology, and Immunology</td> <td>Spousal Partner Abuse Detection & Treatment***</td> </tr> <tr> <td>Biochemistry</td> <td>Medicine</td> <td>Pediatrics</td> <td>Surgery, including Orthopedic Surgery</td> </tr> <tr> <td>Child Abuse Detection and Treatment</td> <td>Neuroanatomy</td> <td>Pharmacology</td> <td>Therapeutics</td> </tr> <tr> <td>Dermatology</td> <td>Neurology</td> <td>Physical Medicine</td> <td>Tropical Medicine</td> </tr> <tr> <td>Embryology</td> <td>Obstetrics and Gynecology</td> <td>Physiology</td> <td>Urology</td> </tr> <tr> <td>Family Medicine*</td> <td>Ophthalmology</td> <td>Preventative Medicine, including Nutrition</td> <td></td> </tr> </table> <p>*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</p>						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	Surgery, including Orthopedic Surgery	Child Abuse Detection and Treatment	Neuroanatomy	Pharmacology	Therapeutics	Dermatology	Neurology	Physical Medicine	Tropical Medicine	Embryology	Obstetrics and Gynecology	Physiology	Urology	Family Medicine*	Ophthalmology	Preventative Medicine, including Nutrition		Rev. L2 Staff Initials & Date <input type="checkbox"/>
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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				<input type="checkbox"/>																																
6. Date the applicant was enrolled in medical school?		(mm/dd/yyyy)				<input type="checkbox"/>																																
7. Date the applicant was issued the diploma of Bachelor/Doctor of Medicine		(mm/dd/yyyy)				<input type="checkbox"/>																																
UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL						Unusual Circumstances <input type="checkbox"/>																																
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				<input type="checkbox"/>																																
9. Was this applicant ever placed on probation?		Yes No				<input type="checkbox"/>																																
10. Was this applicant ever disciplined or placed under investigation?		Yes No				<input type="checkbox"/>																																
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				<input type="checkbox"/>																																
MEDICAL SCHOOL OFFICIAL CERTIFICATION						School Seal <input type="checkbox"/>																																
AFFIX MEDICAL SCHOOL SEAL	<p><i>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.</i></p>																																					
	PRINTED NAME OF SCHOOL OFFICIAL		TITLE OF SCHOOL OFFICIAL			Signature and Date <input type="checkbox"/>																																
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<p>Attention Medical School: THE PERSON WHO SIGNS THIS FORM <u>MAY NOT</u> 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.</p>						L2																																

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