



MEDICAL BOARD OF CALIFORNIA

Licensing Program

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 School Code <input type="checkbox"/>
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					Rev. L2 Staff Initials & Date <input type="checkbox"/>
2. State/Province/Country					<input type="checkbox"/>
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 Anatomy Anesthesia Biochemistry Child Abuse Detection and Treatment Dermatology Embryology Family Medicine*		Geriatric Medicine Histology Human Sexuality Medicine Neuroanatomy Neurology Obstetrics and Gynecology Ophthalmology		Otolaryngology Pain Management and End-of-Life-Care** Pathology, Bacteriology, and Immunology Pediatrics Pharmacology Physical Medicine Physiology Preventative Medicine, including Nutrition	Psychiatry Radiology, including Radiation Safety Spousal Partner Abuse Detection & Treatment*** Surgery, including Orthopedic Surgery Therapeutics Tropical Medicine Urology
<small>*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</small>					
4. Did the applicant withdraw or transfer from this medical school?			Yes	No	<input type="checkbox"/>
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					
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					
AFFIX MEDICAL SCHOOL SEAL	<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>				
	PRINTED NAME OF SCHOOL OFFICIAL		TITLE OF SCHOOL OFFICIAL		School Seal <input type="checkbox"/>
	SIGNATURE OF SCHOOL OFFICIAL		DATE		Signature and Date <input type="checkbox"/>
	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.				

L2

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