



MEDICAL BOARD OF CALIFORNIA

Protecting consumers by advancing high quality, safe medical care.

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

CURRENT POSTGRADUATE TRAINING ENROLLMENT

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				
PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSG TRAINING INFORMATION								
Facility Name								Verified Program Information <input type="checkbox"/>
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								Verified PD Staff Initials & Date Program Director's Signature & Date <input type="checkbox"/> Program Director's Signature <input type="checkbox"/>
ATTENTION PROGRAM DIRECTOR: 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.								
<i>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 RCPSG 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 RCPSG postgraduate training program.</i>								
<p>_____</p> <p>PRINTED NAME OF PROGRAM DIRECTOR</p> <p>_____</p> <p>SIGNATURE OF PROGRAM DIRECTOR (Signature Stamp Is Not Acceptable)</p> <p>_____</p> <p>DATE</p>								
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.								Hospital Seal <input type="checkbox"/>
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.								
_____				HOSPITAL or NOTARY SEAL				
SIGNATURE OF NOTARY PUBLIC								

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