MEDICAL BOARD
OF CALIFORNIA
Protecting consumers by advancing high quality, safe medical care.

Licensing Program
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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 **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 Information ❐

Verified Program Information ❐

Verified PD Staff Initials & Date

Program Director's Signature & Date ❐

Program Director's Signature ❐

Notary Signature & Seal ❐

Hospital Seal ❐

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