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

CERTIFICATE OF CLINICAL TRAINING

(This form is only required of international medical school graduates)

Type or Print Legibly

APPLICANT INFORMATION

LEGAL NAME: Last | First | Middle | Suffix

Date of Birth (m/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School of Graduation

MBC Use Only
Applicant Information ❒

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

Report undergraduate clinical clerkships in which the applicant participated in DIRECT, HANDS-ON DIAGNOSIS OR TREATMENT OF PATIENTS IN A CLINICAL SETTING. *Please use as many forms as necessary to document ALL undergraduate clinical clerkships completed during enrollment in medical school.*

Note: Section 2089.5(c) of the Business and Professions Code requires that instruction in the clinical courses shall total a minimum of 72 weeks. Instruction in the core clinical courses shall total a minimum of 40 weeks in length with a minimum of **(8)** weeks of medicine, **(8)** weeks of surgery, **(6)** weeks of pediatrics, **(6)** weeks of ob/gyn, **(4)** weeks of psychiatry, and **(4)** weeks of family medicine. (Family Medicine is required for applicants who graduated after May 1, 1998)

Rev. L5 Staff Initials & Date

Clinical Subject (List one subject per line)	Facility Name City/State/Province/Country	Dates of Attendance in Chronological Order (mm/dd/yyyy)	Weeks or Weekly Clinical Hours
		Start: End:	
		Start: End:	
		Start: End:	
		Start: End:	
		Start: End:	
		Start: End:	

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MEDICAL SCHOOL OFFICIAL CERTIFICATION

AFFIX MEDICAL SCHOOL SEAL

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.

PRINTED NAME OF SCHOOL OFFICIAL _____ **TITLE OF SCHOOL OFFICIAL** _____

SIGNATURE OF SCHOOL OFFICIAL _____ **DATE** _____

Attention Medical School: THE PERSON WHO SIGNS THIS FORM MAY NOT 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.

School Seal ❒

Signature and Date ❒

L5

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