



# MEDICAL BOARD OF CALIFORNIA

Protecting consumers by advancing high quality, safe medical care.

**Licensing Program**  
2005 Evergreen Street, Suite 1200  
Sacramento, CA 95815-5401  
Phone: (916) 263-2382  
Fax: (916) 263-2487  
www.mbc.ca.gov

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

## Certificate of Individual Clinical Clerkship Training

This form is required of international medical school graduates who completed any clinical training outside of the primary teaching hospital of their medical school. A separate form is to be used for each clinical clerkship.

Type or Print Legibly				APPLICANT INFORMATION				MBC Use Only	
LEGAL NAME:		Last	First	Middle	Suffix		Applicant Information		
Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN		Medical School of Graduation			<input type="checkbox"/>			
PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR TO COMPLETE CLERKSHIP INFORMATION								Verified Information with L5	
Facility Name			Facility Address					<input type="checkbox"/>	
Clinical Specialty			Dates of Training (mm/dd/yyyy)					Clerkship Approved	
			Start Date:		End Date:			<input type="checkbox"/>	
This facility <b>is</b> formally affiliated or has a formal contract of affiliation with a U.S., Canadian, or International Medical School.						Yes		No	
Name of the U.S., Canadian, or International Medical School. (If affiliated)									
This facility <b>does</b> have an ACGME-accredited residency training program.						Yes		No	
ACGME 10-digit program # ( <a href="https://apps.acgme.org/ads/Public">https://apps.acgme.org/ads/Public</a> ):					Specialty:				
OFFICIAL CERTIFICATION								Rev L6 Staff Initials & Date	
<p><b>ATTENTION: A signature stamp is not acceptable. THE PERSON WHO SIGNS THIS FORM <u>MAY NOT</u> BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director or clinical instructor 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.</b></p> <p><i>I certify that I am the program director or clinical instructor and that the applicant named above satisfactorily completed the above named clinical clerkship and I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.</i></p>								Signature & Date	
_____ PRINTED NAME OF PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR						_____ SIGNATURE OF PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR		_____ DATE	
<p><b>NOTE: If a hospital seal is not available, the program director or clinical instructor shall also sign in the section below in the presence of a notary public.</b></p>								Signature	
<p>Signature of Program Director or Clinical Instructor: _____ (SIGN FULL NAME IN THE PRESENCE OF NOTARY)</p>								<input type="checkbox"/>	
<p>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.</p>								Notary Signature & Seal	
State of _____			County of _____					<input type="checkbox"/>	
<p>Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20____,</p>								Hospital Seal	
<p>by, _____ proved to me on the basis of satisfactory evidence (Print Name of Program Director or Clinical Instructor) to be the person who appeared before me.</p>								<input type="checkbox"/>	
_____ SIGNATURE OF NOTARY PUBLIC						<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <b>HOSPITAL or NOTARY SEAL</b> </div>		<input type="checkbox"/>	
								L6	

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