MEDICAL BOARD OF CALIFORNIA

Licensing Program

APPLICATION FOR DUPLICATE CERTIFICATE ***Please print or type***	FOR MEDICAL BOARD USE ONLY Fee Paid: ____ Receipt #: ____ Date Cashiered: ____ Cashier's Intl.: ____ Enforcement Approval: ☐ Yes ☐ No Date: ____ Date Completed: ____

Legal Name:	Last	First	Middle	Suffix

Address of Record: (Current public/mailing address) ***THIS ADDRESS WILL BE DISPLAYED ON YOUR PROFILE ON THE BOARD'S WEBSITE.*** If listing a PO Box, you also must provide a confidential street address.	Mailing Address *(40 characters maximum per line, including spaces)* Mailing Address continued *(40 characters maximum per line, including spaces)* City / State/Province / Zip/Postal Code / Country
Confidential Street Address: (Only required if Address of Record is a P.O. Box)	Confidential Address *(40 characters maximum per line, including spaces)* Confidential Address continued *(40 characters maximum per line, including spaces)* City / State/Province / Zip/Postal Code / Country

Telephone Numbers:	Cell #	Home #	Work #	FAX #

Email Address:

Medical Board of California License/Registration Number:

Please provide all information requested below.

Request for Duplicate Certificate: (Check box for certificate requested)	☐ Duplicate Wall Certificate ☐ Duplicate Wallet (pocket) License
License Type and Fees: (Check box to left of license type) **Only one wall certificate and one wallet license may be issued.**	☐ Physician and Surgeon ($50 each) ☐ Midwife ($25 each) ☐ Research Psychoanalyst ($25 each)
Check all that apply:	☐ Lost ☐ Stolen ☐ Mutilated ☐ Destroyed ☐ Name Change ☐ Address Change ☐ Reinstatement of a revoked certificate (physician and surgeon wall certificate only)

In the event your license was mutilated, or you are requesting a duplicate due to a name or address change, the original wall certificate and/or last wallet [pocket] license issued must be returned to the Board along with this application.

If you indicated lost, stolen, mutilated or destroyed, an explanation of the circumstances is required below.

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BOTH PAGES OF THIS FORM MUST BE COMPLETED.

PHOTO AREA **PASTE A PASSPORT TYPE PHOTO HERE.** **PHOTO MUST BE RECENT AND MUST BE OF YOUR HEAD AND SHOULDER AREAS ONLY WITH CLEAR VIEW OF FACE.** **ALTERED PHOTOS ARE NOT ACCEPTABLE.**	**NOTICE: All items in this application are mandatory; none is voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to identify the licensee and to verify the licensee's identification per Sections 118 and 2432 of the Business and Professions Code. Licensees have the right to review their application subject to the provisions of the Information Practices Act. The chief of the Licensing Program is the custodian of records. Information on this application may be transferred to other governmental or law enforcement agencies.**

AFFIDAVIT

I hereby declare under penalty of perjury under the laws of the State of California that the information provided on this form, including supporting documentation and photograph of me, is true and correct and that I am licensed/registered to practice in the State of California.

____ ____________________

Applicant's Signature Date

State of ____________________________________

County of __________________________________

Subscribed and sworn to (or affirmed) before me on

this ________________ day of ____, 20_________,

by: (applicant's name printed here) ____

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

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Signature of Notary Public