



MEDICAL BOARD OF CALIFORNIA
Licensing Program



LICENSING FEE INVOICE

ATS NUMBER

Empty rectangular box for ATS number.

Name: _____
(Last) (First) (MI)

Birth Date: _____ Amount Due: \$ _____

Please make your certified check, cashier's check, or money order payable to
Medical Board of California

Note: PAYMENTS RECEIVED WITHOUT THIS INVOICE MAY DELAY PROCESSING OF
YOUR APPLICATION.

LICENSING OFFICE USE ONLY:

US or IMG
(Circle One)

ABOVE FEE(S): 76T (\$783) 76V (\$391.50) APP (\$442) FP (\$49) VL3 (\$25) Staff Initials: _____
(Circle the applicable account code)

TRANSFER FEES

Transfer fees
From Account: _____ ATS #: _____ Receipt #: _____ Date Received: _____

Transfer fees
To Account: _____ ATS #: _____ Include payment above? Yes or No
(Circle One)

Note to cashier staff:

Three horizontal lines for notes to cashier staff.

CASHIERING OFFICE USE ONLY:

Receipt #: _____ Date Received: _____ Amount: _____ Initials: _____