MEDICAL BOARD OF CALIFORNIA
Licensing Program

APPLICATION TO RESTORE LICENSE TO FULL, ACTIVE STATUS FROM INACTIVE, DISABLED OR FEE EXEMPT STATUS OR FROM DISABLED STATUS TO ACTIVE STATUS WITH LIMITATIONS ON PRACTICE

Please print or type. Illegible applications will be returned.

FOR MEDICAL BOARD USE ONLY

Fee paid:_____ Receipt #:_____

Date Cashiered:_____ Cashier's Intl.:_____

Date Approved:_____ Date Denied:_____

Enforcement Approval: Yes___ No:___ Date:_____

Signature:

Name (first, middle, last):

Address of record (Current public/mailing address. If using a PO Box, you must also provide a confidential street address.)
This is the address that will be displayed on the Medical Board's website.

Confidential street address:

Telephone Number:	**California Medical License Number:**
Fax Number:	**E-mail:**

Current status of your license: (Check one box only.)

- ☐ Retirement (see Part 1)
- ☐ Military Service (see Part 2)
- ☐ Voluntary Services (see Part 3)
- ☐ Inactive (see Part 4)
- ☐ Disabled (see Part 5)

Please note the renewal cycle is based upon your date of birth. Those persons choosing to restore a license to active status during the middle of a renewal cycle, depending upon date of birth, may have a renewal period of less than 24 months.

Part 1 - RETIRED STATUS *(Please provide all information requested below.)*

Your license must be current at time of application. You are required to submit payment of the current (active license) fee with this application. Please contact the Board for information on fees due.

You must document completion of 50 hours of continuing medical education (CME) within the past two years. Documentation certifying compliance with this requirement must be submitted with this application.

Acceptable documents are letters or certificates of attendance that show completion of CME courses, the name of the provider, the name and date of the course, the number of approved CME hours completed and your name as the participant.

If you are engaged in an approved postgraduate residency training program, or engaged in an approved clinical fellowship program you must submit a letter from the hospital verifying the beginning and ending dates of training.

If necessary, you may need to contact your CME provider to obtain documents verifying your participation. Please send in photocopies of your documents with this application.

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2944 www.mbc.ca.gov

Part 2 - MILITARY STATUS *(Please provide all information requested below.)*

A fee is required if you have been discharged from full-time active service or you are still in the military and are canceling your "military" license to restore your license to an active unrestricted status.

If it has been more than 60 days since your discharge from active service and you have not paid your fees, you will be required to submit payment of any accrued renewal fees, and a delinquent fee.

Please contact the Board for information on fees due.

Indicate branch of service. (Check one box only.)

☐ Air Force ☐ Army ☐ Marines ☐ Navy ☐ U.S. Public Health Service

Have you been granted a continuing medical education (CME) waiver? ☐ No ☐ Yes

If you were granted a waiver, you must document completion of 50 hours of continuing medical education (CME) within the past two years.

Documentation certifying compliance with this requirement must be submitted with this application.

Acceptable documents are letters or certificates of attendance that show completion of CME courses, the name of the provider, the name and date of the course, the number of approved CME hours completed and your name as the participant. If you are engaged in an approved postgraduate residency training program, or engaged in an approved clinical fellowship program, you must submit a letter from the hospital verifying the beginning and ending dates of training.

If necessary, you may need to contact your CME provider to obtain documents verifying your participation. Please send in photocopies of your documents with this application.

Are you still in the military?

☐ No Please provide dates of service or training:

From (Month/Day/Year) _____ To (Month/Day/Year) _____

☐ Yes Please provide expected date of discharge and/or retirement from active service or full-time training:

Month _____ Day _____ Year _____

Part 3 - VOLUNTARY SERVICES (*Please provide all information requested below.)*

Your license must be current at time of application. You are required to submit payment of the current (active license) fee. Please contact the Board for information on fees due.

You must document completion of 50 hours of continuing medical education (CME) within the past two years. Documentation certifying compliance with this requirement must be submitted with this application.

Acceptable documents are letters or certificates of attendance that show completion of CME courses, the name of the provider, the name and date of the course, the number of approved CME hours completed and your name as the participant. If you are engaged in an approved postgraduate residency training program or engaged in an approved clinical fellowship program, you must submit a letter from the hospital verifying the beginning and ending dates of training.

If necessary, you may need to contact your CME provider to obtain documents verifying your participation. Please send in photocopies of your documents with this application.

Part 4 - INACTIVE STATUS (*Please provide all information requested below.)*

You must document completion of 50 hours of continuing medical education (CME) within the past two years. Documentation certifying compliance with this requirement must be submitted with this application.

Acceptable documents are letters or certificates of attendance that show completion of CME courses, the name of the provider, the name and date of the course, the number of approved CME hours completed and your name as the participant. If you are engaged in an approved postgraduate residency training program, or in an approved clinical fellowship program, you must submit a letter from the hospital verifying the beginning and ending dates of training.

If necessary, you may need to contact your CME provider to obtain documents verifying your participation. Please send in photocopies of your documents with this application.

If your license is delinquent, you are required to submit payment of any accrued renewal fees, a delinquent fee and penalty fee, if applicable with this application. Please contact the Board for information on fees due.

Part 5 - DISABLED STATUS (*Please provide all information requested below.)*

A licensee who has been granted a license under disabled status, shall not engage in the practice of medicine until he or she does the following:

- Establishes to the satisfaction of the Board under penalty of perjury that the licensee's disability either no longer exists or does not affect his or her ability to practice medicine safely; or, agrees under penalty of perjury to limit his or her practice in the manner prescribed by his or her reviewing physician.
- Payment of the current (active license) fee must be submitted with this application. Please contact the Board for information on fees due.
- Document completion of 50 hours of continuing medical education (CME). Documentation certifying compliance with this requirement must be submitted with this application. Acceptable documents are letters or certificates of attendance that show completion of CME courses, the name of the provider, the name and date of the course, the number of approved CME hours completed and your name as the participant. If you are engaged in an approved postgraduate residency training program or engaged an in approved clinical fellowship program, you must submit a letter from the hospital verifying the beginning and ending dates of training.

  If necessary, you may need to contact your CME provider to obtain documents verifying your participation. Please send in photocopies of your documents with this application.

Are you applying to restore your license to:
(Check one box only)

☐ Active Unrestricted Status

☐ Active Status with Limitations on Practice (Describe below)

Please describe specific practice limitations (e.g., no surgery):

Approximate date disability began: (Month/Day/Year)

Duration of disability: ☐ Temporary ☐ Permanent

Will you be practicing medicine: ☐ Full-Time ☐ Part-Time

Activities in medicine:
Check the appropriate box on each line to indicate hours per week for each of the following activities.

	None	1-9	10-19	20-29	30-39	40 or more
Patient Care	☐	☐	☐	☐	☐	☐
Research	☐	☐	☐	☐	☐	☐
Teaching	☐	☐	☐	☐	☐	☐
Administration	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

Part 5 - DISABLED STATUS (Continued) ***The following section must be completed by your attending physician.***

NOTE TO ATTENDING PHYSICIAN: If "disabled" was checked on this application, the applicant previously submitted an application for "disabled" status to the Medical Board of California, which was approved. The applicant documented the inability to practice medicine due to a disability or illness. The applicant is now requesting to be removed from "disabled" status and to be permitted to practice medicine. Under state law, the applicant must establish to the satisfaction of the Board that the illness or disability no longer exists or does not affect the applicant's ability to practice medicine safely. **As the applicant's attending physician, please provide the information requested below.**

In the space below, please provide a summary of the applicant's case history, including the diagnosis or description of the applicant's disability. Indicate whether you have reviewed the applicant's medical records related to his or her disability. If additional space is needed, please include an attachment.

In the space below, please provide a summary of the applicant's current state of health including any changes in his or her health that now enable the applicant to return to the practice of medicine. Please describe the applicant's course of treatment, if applicable for the type of disability or illness. If additional space is needed, please include an attachment.

Does the applicant's current state of health prevent the applicant from practicing medicine safely? ☐ No ☐ Yes
If yes, please explain in the space below. If additional space is needed, please include an attachment.

If the applicant requires any limitations or has agreed to limit his or her practice, please describe all recommended practice limitations and how those limitations permit the applicant to practice medicine safely. Please also describe specific practice limitations (e.g., no surgery). If additional space is needed, please include an attachment.

Attending Physician's Name/Specialty | **Telephone Number**

Attending Physician's Address | **City** | **State** | **Zip**

I certify under penalty of perjury under the laws of the State of California that the information I have provided in this application, including supporting documents, is true and correct and that I am licensed to practice in the United States of America.

Attending Physician's Signature | **Date**

Attending Physician's License Number | **Attending Physician's State of Licensure**

FINANCIAL INTEREST

California's Financial Interest Disclosure law (Business and Professions Code section 2426) requires you to disclose any financial interest that you or your immediate family have in specified health-related facilities located in or outside the State of California. Immediate family means a spouse, child or parent of a licensee, and a spouse of a child of a licensee.

Financial interest includes any type of ownership interest including share or stock ownership, limited partnership interest, debt, loan, lease, compensation, remuneration, general or limited partnership interest, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment of money or anything else of value to a licensee or the licensee's immediate family from a health-related facility.

Health-related facility means any facility that provides clinical laboratory services, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, diagnostic imaging, or outpatient surgery centers. Diagnostic imaging includes all X-ray, computed axial tomography, magnetic resonance imaging, nuclear medicine, positron emission tomography, mammography and ultrasound goods and services.

A financial interest does not include the ownership of corporate investment securities, including shares, bonds, or other debt instruments that (1) are purchased from a licensed securities broker on terms available to the general public through a licensed securities exchange or NASDAQ, (2) do not base any profit distributions or other transfers of value on the licensee's referral of patients, (3) do not have a separate class or accounting for any persons or licensees who may make patient referrals to the corporation, and (4) are in a corporation that has total gross assets exceeding $100,000,000.

Do you have financial interest to report? ☐ **NO** ☐ **YES* (please list the name(s) and address(es) in the space below.**

If you answered "yes" to having financial interest to report, please list the name(s) and address(es) of each health-related facility in which you or your immediate family have a financial interest.

Health-Related Facility Name(s)	Facility's Address

I certify under penalty of perjury under the laws of the State of California that I read and understand the information defining financial interest and that either I have disclosed on this application the names of those health-related facilities in which I or my family have a financial interest, or I do not have any financial interest to disclose.

Applicant's Signature:_____ **Date:**_____

You must disclose, if since your last renewal, you have had any license disciplined by a government agency, or have been convicted of, or pled guilty, to any crime. Do not list charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions two years or older under California Health and Safety Code Sections 11357(b), (c), (d), (e), or section 11360(b).

"Conviction" includes a plea of no contest and any conviction that has been set aside or deferred pursuant to Penal Code section 1000 or 1203.4, including infractions, misdemeanor, and felonies.

You do not need to report a conviction for an infraction with a fine of less than $300.00 unless the infraction involved alcohol or controlled substances. You must, however, disclose any conviction which you entered a plea of no contest and any convictions that were subsequently set aside pursuant to Penal Code sections 1000 or 1203.4.

"License" includes permits, registrations, and certificates. "Discipline" includes, but is not limited to, suspension, revocation, voluntary surrender, probation, or any other restrictions.

Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A., and its territories, military court or a foreign country? ☐ **NO** ☐ **YES**

I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION CONTAINED IN THIS APPLICATION, INCLUDING SUPPORTING DOCUMENTS, IS TRUE AND CORRECT AND THAT I AM LICENSED TO PRACTICE IN THE STATE OF CALIFORNIA.

Applicant's Signature:_____ **Date:**_____

All items in this application are mandatory. This information is requested by the Licensing Program of the Medical Board of California. Failure to provide any of the requested information will result in this application being rejected as incomplete. The Licensing Program Chief is the custodian of records. Access to records by the individual to whom they pertain may be obtained under the Information Practices Act by contacting the custodian of records at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815. Information in this application may be transferred to other governmental and law enforcement agencies.