



## MEDICAL BOARD OF CALIFORNIA Licensing Program



<p><b>APPLICATION FOR A DUPLICATE FICTITIOUS NAME PERMIT</b> (Fee - \$30) <i>Please print or type.</i> <i>Illegible applications will be returned.</i></p>	<p><b>FOR OFFICE USE ONLY</b></p>												
	Fee Paid: _____ Receipt #: _____ Date Cashiered: _____ Cashier's Intl.: _____ Date Approved: _____ Date Denied: _____												
Owner / Co-owner (first, middle, last):													
Social Security Number/FEIN:													
Address: List current address													
Is this an address change?	<input type="checkbox"/> Yes <input type="checkbox"/> No												
Telephone Number: Fax Number (if applicable):	Telephone FAX												
Fictitious Name:													
Fictitious Name Permit Number:													
<p><i>Please provide all information requested below.</i></p>													
Request for Duplicate Permit: (Check box to left of certificate requested.)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"></td> <td style="width: 33%; text-align: center;">Duplicate Original Permit</td> <td style="width: 33%; text-align: center;">Duplicate Renewal Permit</td> </tr> <tr> <td>Check all that apply:</td> <td style="text-align: center;">Lost</td> <td style="text-align: center;">Stolen</td> </tr> <tr> <td></td> <td style="text-align: center;">Destroyed</td> <td style="text-align: center;">Address Change</td> </tr> <tr> <td></td> <td></td> <td style="text-align: center;">Mutilated</td> </tr> </table>		Duplicate Original Permit	Duplicate Renewal Permit	Check all that apply:	Lost	Stolen		Destroyed	Address Change			Mutilated
	Duplicate Original Permit	Duplicate Renewal Permit											
Check all that apply:	Lost	Stolen											
	Destroyed	Address Change											
		Mutilated											
If you indicated lost, stolen, mutilated or destroyed, an explanation of the circumstances is required below (in the event your permit was mutilated, or you are requesting a duplicate due to name or address change, the original permit must be surrendered to our office along with this request).													
I certify under penalty of perjury under the laws of the State of California that the information provided in this application, including any supporting documents, are true and correct and that I am licensed/registered to practice in the State of California.													
_____ Physician Signature	_____ License Number	_____ Date											

**BOTH PAGES OF THIS FORM MUST BE COMPLETED.**

**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 verify the identity of the licensee per Sections 118 and 2432 of the Business and Professions Code. Applicants have the right to review their application subject to the provisions of the Information Practices Act. The Licensing Program chief is the custodian of records. Information provided in this application may be transferred to other governmental or law enforcement agencies.

Disclosure of your Social Security number (SSN) or Federal Employer Identification Number (FEIN) is mandatory. Section 30 of the Business and Professions Code and Public Law 94.455 (42 USCA 405(c)(2)(C) authorize collection of your SSN. Your SSN or FEIN will be used for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your SSN or FEIN, your application will not be processed and you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

**NOTARY**

This individual, \_\_\_\_\_, has appeared before me, signed in my presence and is identified as the above individual. Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public Signature

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Address

My commission expires \_\_\_\_\_.

SEAL