

MEDICAL BOARD OF CALIFORNIA

Refer to www.mbc.ca.gov for office locations



Quarterly Declaration

INSTRUCTIONS: Please type or print neatly. ALL requested information and questions on this form must be answered. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the Declaration. You may wish to make and retain a copy of the material submitted to the Medical Board. Mail the completed Declaration to your assigned probation monitor. DO NOT FAX your Declaration, the Medical Board requires an original signature on each quarterly declaration and a faxed signature will not be accepted.

Check Appropriate Box for Reporting Period Covered

Reporting Period	Due to the Board By
<input type="checkbox"/> January - March (First Quarter)	April 10
<input type="checkbox"/> April - June (Second Quarter)	July 10
<input type="checkbox"/> July - September (Third Quarter)	October 10
<input type="checkbox"/> October - December (Fourth Quarter)	January 10

Name:	First	Middle	Last	Aliases
Home Address:	Number & Street	City	State	Zip Phone Number
Primary Place of Practice (include additional places of practice on reverse)				
Address:	Number & Street	City	State	Zip Phone Number
E-mail Address:	Work _____ Personal _____			Cell Phone Number
Indicate the number of hours worked this quarter at your primary place of practice:			What is your work schedule at this place of practice?	
Per week		Per month		

The Following Questions Refer to the Time Period Since Your Last Quarterly Declaration

1. Have you violated any county or city ordinances, been arrested, charged, convicted of, pled nolo contendere in any state or federal court or foreign country to any misdemeanor, felony, or other offense? (If yes, specify which one in your explanation. Exclude parking tickets.) Yes* No
2. Have you violated, been arrested, convicted of, or received a citation for driving under the influence of alcohol or drugs, reckless driving, or any other vehicle code violation involving alcohol or drugs? Yes* No
3. Are you required to undergo biological fluid testing? If yes, when were you last tested and what is the frequency of testing? Yes* No
4. Is there any civil suit, malpractice, or peer review proceeding pending against you? Yes* No
5. Have you resigned from any employment or has your employment been terminated? Yes* No
6. Are you in the process of applying for any other business or professional license or certificate? Yes* No
7. Have you had to report any theft or loss of controlled substances to the Department of Justice? Yes* No
8. Have any of your patients died during the last quarter? Yes* No
9. Did you cease practicing since your last report? If yes, give the date you ceased practice. Yes* No

(Continued on reverse)

(Continued)

10. Have you been denied, had a license or certificate to practice a business or profession suspended, revoked, or surrendered or otherwise disciplined by any other federal, state, government agency or other country? Yes* No
11. Have you maintained a current and valid license? Yes No*
12. Are you current with your probation monitoring costs? Yes No*
13. Have you complied with each term and condition of your probation? Yes No*

***IF YOU ANSWERED YES, to the above question numbers 1 through 10 or NO to question numbers 11 through 13, you must explain in detail, on an attached sheet of paper.**

List the name, address, and work schedule (hours/days) of any other locations where you practice medicine (i.e., convalescent/nursing homes, etc.) Provide the phone number of the Medical Director or Chief of Staff, if applicable.

Provide the titles of continuing education courses you have completed for this quarter, if any. Attach a copy of the CME certificate(s).

Do you practice any type of specialty? If yes, please describe which specialty.

List any new staff and include their title and license number, if applicable.

What question(s), if any, do you have for your probation monitor regarding your probation.

Executed on _____, 20_____, at _____, _____
City State

I hereby submit this Quarterly Declaration as required by the Medical Board of California and its Order of probation thereof and declare under penalty of perjury under the laws of the State of California that I have read the foregoing declaration and any attachments in their entirety and know their contents and that all statements made are true in every respect and I understand and acknowledge that any misstatements, misrepresentations, or omissions of material fact may be cause for further disciplinary action.

Probationer (print name)

Signature