



# MEDICAL BOARD OF CALIFORNIA

Protecting consumers by advancing high quality, safe medical care.

**Licensing Program**  
2005 Evergreen Street, Suite 1200  
Sacramento, CA 95815-5401  
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Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

## APPLICATION FOR CANCELLATION OF A FICTITIOUS NAME PERMIT

**Please print or type.**  
**Illegible applications will be returned.**

<b>Fictitious Name:</b>				
<b>Fictitious Name Permit Number:</b>				
<b>Expiration Date:</b>				
<b>Practice Address:</b>				
<b>Contact Person's Name:</b>				
<b>Address:</b>				
<b>Contact's Telephone Number:</b>		<b>FAX:</b>		
<b>FAX Number (if applicable):</b>				
<b>Reasons for Cancellation:</b>	<input type="checkbox"/>	<b>Out of Business</b>	<input type="checkbox"/>	<b>Change in Ownership</b>
	<input type="checkbox"/>	<b>Dissolution of Solo Practice</b>	<input type="checkbox"/>	<b>Dissolution of Partnership</b>
	<input type="checkbox"/>	<b>Dissolution of Group</b>	<input type="checkbox"/>	<b>Dissolution of Corporation</b>
	<input type="checkbox"/>	<b>Change in original filing status</b>	<input type="checkbox"/>	<b>Other:</b>

**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 and identify the licensee's identification 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.**

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

**FOR INDIVIDUALS (SOLE PROPRIETORS), GROUPS, AND PARTNERSHIPS ONLY**

The following must be signed by a licensed physician and surgeon or podiatrist who is recognized by the Medical Board as being a current owner of the Fictitious Name Permit.

I am/was an owner who holds the permit \_\_\_\_\_  
(COMPLETE FICTITIOUS NAME)

and as such declare that I am authorized to act on behalf of all other owners and that said owners are aware that this application is being submitted to the Medical Board of California's Licensing Program for the cancellation of the fictitious name permit named in this application. I have read the foregoing application and all attachments thereto and know the contents thereof, and the same are true of my own knowledge. I certify under penalty of perjury under the laws of the State of California that the information I have provided is true and correct.

Executed at \_\_\_\_\_, California, this \_\_\_ day of \_\_\_\_\_, 20\_\_

**BY:**

NAME (please type or print)	SIGNATURE	MEDICAL LICENSE #

**FOR CORPORATIONS ONLY**

The following must be signed by a licensed physician and surgeon or podiatrist who is recognized by the Medical Board as being a current owner of the Fictitious Name Permit.

I am/was a shareholder of \_\_\_\_\_  
(COMPLETE CORPORATE NAME)

and as such declare that I am authorized to act on behalf of the corporation and that all corporate officers and shareholders are aware that this application is being submitted to the Medical Board of California's Licensing Program for the cancellation of the fictitious name permit named in this application. I have read the foregoing application and all attachments thereto and know the contents thereof, and the same are true of my own knowledge. I certify under penalty of perjury under the laws of the State of California that the information I have provided is true and correct.

Executed at \_\_\_\_\_, California, this \_\_\_ day of \_\_\_\_\_, 20\_\_

**BY:**

NAME (please type or print)	SIGNATURE	MEDICAL LICENSE #

**FICTITIOUS NAME:**

**FICTITIOUS NAME PERMIT NUMBER:**