



MEDICAL BOARD OF CALIFORNIA

Protecting consumers by advancing high quality, safe medical care.

Licensing Program
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Sacramento, CA 95815-5401
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www.mbc.ca.gov

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

APPLICATION FOR DUPLICATE CERTIFICATE		FOR MEDIC BOARD USE ONLY			
<i>Please print or type</i>		Fee paid: _____		Receipt #: _____	
		Date Cashiered: _____		Cashier's Intl.: _____	
		Enforcement Approval: Yes <input type="checkbox"/> No <input type="checkbox"/>		Date: _____	
		Date Completed: _____			
Legal Name:	Last	First	Middle	Suffix	
Address of Record: (Current public/mailling address) THIS ADDRESS WILL BE DISPLAYED ON YOUR PROFILE ON THE BOARD'S WEBSITE. If listing a PO Box, you also must provide a confidential street address.		Mailing Address (40 characters maximum per line, including spaces)			
		Mailing Address continued (40 characters maximum per line, including spaces)			
		City	State/Province	Zip/Postal Code	Country
Confidential Street Address: (Only required if Address of Record is a P.O. Box)		Confidential Address (40 characters maximum per line, including spaces)			
		Confidential Address continued (40 characters maximum per line, including spaces)			
		City	State/Province	Zip/Postal Code	Country
Telephone Numbers:	Cell #	Home #	Work #	FAX #	
Email Address:					
Medical Board of California License/Registration Number:					
Please provide all information requested below.					
Request for Duplicate Certificate: (Check box for certificate requested)		<input type="checkbox"/> Duplicate Wall Certificate <input type="checkbox"/> Duplicate Wallet (pocket) License			
License Type and Fees: (Check box to left of license type) Only one wall certificate and one wallet license may be issued.		<input type="checkbox"/> Physician and Surgeon (\$50 each) <input type="checkbox"/> Midwife (\$25 each) <input type="checkbox"/> Research Psychoanalyst (\$25 each)			
Check all that apply:		<input type="checkbox"/> Lost <input type="checkbox"/> Stolen <input type="checkbox"/> Mutilated <input type="checkbox"/> Destroyed <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Reinstatement of a revoked certificate (physician and surgeon wall certificate only)			
In the event your license was mutilated, or you are requesting a duplicate due to a name or address change, the original wall certificate and/or last wallet [pocket] license issued must be returned to the Board along with this application. If you indicated lost, stolen, mutilated or destroyed, an explanation of the circumstances is required below.					

BOTH PAGES OF THIS FORM MUST BE COMPLETED.

<p>PHOTO AREA</p> <p>PASTE A PASSPORT TYPE PHOTO HERE.</p> <p>PHOTO MUST BE RECENT AND MUST BE OF YOUR HEAD AND SHOULDER AREAS ONLY WITH CLEAR VIEW OF FACE.</p> <p>ALTERED PHOTOS ARE NOT ACCEPTABLE.</p>	<p>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 identify the licensee and to verify the licensee's identification per Sections 118 and 2432 of the Business and Professions Code. Licensees have the right to review their application subject to the provisions of the Information Practices Act. The chief of the Licensing Program is the custodian of records. Information on this application may be transferred to other governmental or law enforcement agencies.</p>
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AFFIDAVIT

I hereby declare under penalty of perjury under the laws of the State of California that the information provided on this form, including supporting documentation and photograph of me, is true and correct and that I am licensed/registered to practice in the State of California.

Applicant's Signature

Date

<p>State of _____</p> <p>County of _____</p> <p>Subscribed and sworn to (or affirmed) before me on</p> <p>this _____ day of _____, 20____,</p> <p><u>by: (applicant's name printed here)</u> _____</p> <p>proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.</p>	
<p>NOTARY SEAL</p>	<p>_____ Signature of Notary Public</p>