



PERSONAL INFORMATION

MBC USE ONLY

Medical Board of California License/Registration Number:

Lic/Reg #

Full Legal Name

Full Last Name	First Name	Middle Name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Name

Address Of Record Current public/mailling address. Pursuant to Business and Professions Code Section 2021(a)(b), the Address of Record is public information and will be displayed on your profile on the Medical Board's website.

AOR

Line 1 (40 characters per line, including spaces)		Line 2 (40 characters per line, including spaces)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
City	State/Province	Zip/Postal Code	Country
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Previous Address Of Record If the Address of Record listed above is new, please list your previous address of record.

Line 1 (40 characters per line, including spaces)		Line 2 (40 characters per line, including spaces)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
City	State/Province	Zip/Postal Code	Country
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Confidential Address If the Address of Record is a Post Office Box, a confidential street address must also be reported.
NOTE: The street address of a private mail box service may not be used as a confidential street address.

Line 1 (40 characters per line, including spaces)		Line 2 (40 characters per line, including spaces)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
City	State/Province	Zip/Postal Code	Country
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Telephone Numbers (Include area code)

Primary	Cell	Work
<input type="text"/>	<input type="text"/>	<input type="text"/>

Phone

Email Address (Required)

Email

SELECT THE LICENSE TYPE

Cert Type

Only one wall certificate may be issued.

- Physician's and Surgeon's (\$50)
 Midwife (\$25)
 Research Psychoanalyst (\$25)

REASON FOR REQUEST (Check All That Apply)

Reason

- Lost
 Name Change
 Destroyed
 Mutilated
 Stolen
 Not Received Yet
 Reinstatement of a revoked certificate

NOTE: In the event your wall certificate was mutilated, or you are requesting a duplicate due to a name change, the original wall certificate 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.

Exp

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Fee Paid _____ Receipt # _____ Enforcement Approval Yes No Date _____

Date Cashiered _____ Cashier's Initial _____ Date Completed _____

Form **DUP1**

Applicant Full Legal Name

License/Registration Number

PHOTOGRAPH AND NOTICE

Photo
○

Affix a 2" by 2" photo here.
Photo must be recent and must be of your head and shoulder areas only.
Altered photos are NOT acceptable.

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.

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.

Licensee Signature and Date
○

SIGN LEGAL NAME: _____ **DATE:** _____

NOTARY SECTION

Licensee Signature
○

SIGNATURE OF APPLICANT: _____
(SIGN LEGAL NAME IN THE PRESENCE OF NOTARY)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of _____ County of _____

Subscribed and sworn to (or affirmed) before me on this

_____ day of _____, 20____,

Print Applicant's Legal Name

by,

proved to me on the basis of satisfactory evidence to be the person who appeared before me.

Licensee Name and Date
○
Notary Signature and Seal
○

(NOTARY SEAL)

SIGNATURE OF NOTARY PUBLIC

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Reviewed DUP1 ○
DUP2 ○

Staff Initials _____
Date _____

Form **DUP2**