



# DOCS Portal

The Medical Board of California's (Board) Direct Online Certification Submission (DOCS) portal allows medical schools and postgraduate training programs to electronically submit primary source verification documents securely and efficiently to the Board for a physician's and surgeon's or postgraduate training license application.

## DOCS Fast Facts

- Medical schools and postgraduate training programs submit electronic documents effortlessly
- Immediate receipt of documents
- It's quick and easy to register
- No medical school or postgraduate training seals required

## Register for the DOCS Portal



### STEP 1

Submit DOCS Portal Registration Form to the Board



### STEP 2

The Board creates an account for authorized users



### STEP 3

Upload documents electronically through DOCS Portal

The DOCS Portal Registration Form is required for all medical schools and postgraduate training programs that wish to submit primary source verification documents electronically to the Board. DOCS Portal registration forms are located on the Board's website or by emailing [DOCS@mbc.ca.gov](mailto:DOCS@mbc.ca.gov).



**MEDICAL BOARD**  
OF CALIFORNIA  
2005 Evergreen Street, Suite 120  
Sacramento, CA 95815

**CONTACT**  
(916) 263 2382  
[WWW.MBC.CA.GOV/FORMS](http://WWW.MBC.CA.GOV/FORMS)  
[DOCS@MBC.CA.GOV](mailto:DOCS@MBC.CA.GOV)

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This form is intended for use by medical schools and residency programs to register authorized users to submit documents to the Medical Board of California (Board) electronically through the DOCS Portal.

**Check One:** ☐ **Medical School** ☐ **Postgraduate Training Program**

Medical School Name / Postgraduate Training Facility Name

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**AUTHORIZED PROGRAM INFORMATION** (Postgraduate Training Programs Only)

If you have more than three programs, please attach additional information on a separate sheet

<b>1.</b>	Program Name	10-digit ACGME Number
<b>2.</b>	Program Name	10-digit ACGME Number
<b>3.</b>	Program Name	10-digit ACGME Number

**AUTHORIZED USER 1 (THIS SECTION MUST BE COMPLETED BY USER 1)**

Name	Title
Email Address	Phone Number

I acknowledge that I am being authorized to submit documents to the Medical Board of California on behalf of the Medical School Dean or Registrar / Program Director / GME Director and certify that I will only submit documents as authorized and that each document I submit will be a true and correct copy of the original.

**Signature of Designee/Authorized User**

\_\_\_\_\_  
(Original signature required) Date: \_\_\_\_\_

**AUTHORIZED USER 2 (THIS SECTION MUST BE COMPLETED BY USER 2)** if applicable

Name	Title
Email Address	Phone Number

I acknowledge that I am being authorized to submit documents to the Medical Board of California on behalf of the Medical School Dean or Registrar / Program Director / GME Director and certify that I will only submit documents as authorized and that each document I submit will be a true and correct copy of the original.

**Signature of Designee/Authorized User**

\_\_\_\_\_  
(Original signature required) Date: \_\_\_\_\_

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**AUTHORIZED USER 3 (THIS SECTION MUST BE COMPLETED BY USER 3) if applicable**

Name	Title
Email Address	Phone Number

I acknowledge that I am being authorized to submit documents to the Medical Board of California on behalf of the Medical School Dean or Registrar / Program Director / GME Director and certify that I will only submit documents as authorized and that each document I submit will be a true and correct copy of the original.

**Signature of Designee/Authorized User**

\_\_\_\_\_ **Date:** \_\_\_\_\_

(Original signature required)

**AUTHORIZED USER 4 (THIS SECTION MUST BE COMPLETED BY USER 4) if applicable**

Name	Title
Email Address	Phone Number

I acknowledge that I am being authorized to submit documents to the Medical Board of California on behalf of the Medical School Dean or Registrar / Program Director / GME Director and certify that I will only submit documents as authorized and that each document I submit will be a true and correct copy of the original.

**Signature of Designee/Authorized User**

\_\_\_\_\_ **Date:** \_\_\_\_\_

(Original signature required)

**THIS SECTION MUST BE COMPLETED BY:****Dean of Medical School, Medical School Registrar, Program Director, Designated Institutional Official (DIO) or GME Director**

Name	Title
Email Address	Phone Number

I hereby certify that the individual(s) listed on this form are authorized by me to submit documents through this portal on my behalf. I understand that I am responsible for notifying the Board within 30 days if the designated staff noted above separates from the medical school/postgraduate training program.

**Signature of Medical School Dean or Registrar / Program Director / GME Director**

\_\_\_\_\_ **Date:** \_\_\_\_\_

(Original signature required)

**Attention Postgraduate Training Programs:** Only the GME Director, DIO or Program Director may sign and submit this form to the Board. If signature authority is being delegated to another person who is added above, evidence of that delegation must be attached to this form (photocopy is acceptable). Such delegation must be on official letterhead and dated within 12 months.

**Electronic Signatures:** Please refer to the Electronic Signatures information on the [Third Party Services webpage](#) for acceptable ways to sign this document.