Medical Board of California

Application for a Physician's and Surgeon's License

Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
www.mbc.ca.gov

MBC USE ONLY

TYPE OF APPLICATION

App Type ○

(Select One)

☐ **U.S. or Canadian Medical School Graduate** ☐ **International Medical School Graduate**

(Select One)		(Optional)
☐ **Physician's and Surgeon's Certificate**	☐ **Previously Licensed**	☐ **Limited Practice License**

PRIORITY REVIEW AND EXPEDITED LICENSURE

Satisfactory evidence must be provided with your application. See License Information & Checklist for details.

Priority Review ○

☐ **Honorably Discharged Veterans of the United States Armed Forces**

☐ **Practice in Medically Underserved Area or Population**

☐ **Temporary License for Spouse of Active Duty Member of the United States Armed Forces**

☐ **Admitted to the United States as a Refugee, Granted Asylum, or Have a Special Immigrant Visa Status**

PERSONAL INFORMATION

Full Legal Name

Legal Name ○

Full Last Name	First Name	Middle Name	Suffix

Other Names/Alias

Date of Birth

DOB ○

(mm/dd/yyyy)

SSN/ITITN ○

☐ **Social Security Number or**
☐ **Individual Taxpayer Identification Number**

Gender ☐ **Female** ☐ **Male** ☐ **Non-Binary**

Gender ○

Telephone Numbers
(Include area code)

Primary	Cell	Work

Phone ○

Email Address (Required)

Email ○

Address Of Record

This address will be used for all current correspondence during the review process and will be posted on the Board's website upon issuance of a license. If you are using a P.O. Box, you are also required to list a confidential street address.

AOR ○

Line 1 (40 characters per line, including spaces)		Line 2 (40 characters per line, including spaces)	
City	State/Province	Zip/Postal Code	Country

Confidential Address

Only required if Address of Record is a P.O. Box

Conf. Address ○

Line 1 (40 characters per line, including spaces)		Line 2 (40 characters per line, including spaces)	
City	State/Province	Zip/Postal Code	Country

1. Are you a registered sex offender? ☐ Yes ☐ No

Sex Offender ○

2. Have you served or are you currently serving in the United States Armed Forces? ☐ Yes ☐ No

Military Service ○

3. Are you requesting expediting of this application as a spouse or domestic partner of an active duty member of the United States Armed Forces? ☐ Yes ☐ No

Spouse or Partner ○

MBC USE ONLY	Cashiering	Modifier	School Code

Form **L1A**

Applicant Full Legal Name _____ **Date of Birth** (mm/dd/yyyy) _____

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PREVIOUS APPLICATION OR LICENSE

A "yes" response to questions 4-5 requires a signed and dated written explanation. Use the Explanation For Application Question (Form EXP) to provide your explanation.

Name & DOB ○

4. Have you ever filed an application for a physician's and surgeon's license or other license in California that has been withdrawn, abandoned, or denied? ☐ Yes ☐ No

Previous App/License ○

5. Have you previously held a physician's and surgeon's license in California? ☐ Yes ☐ No ○

If yes, please provide license number: _____ Expired: _____

EXAMINATIONS

6. Are you certified by the Educational Commission for Foreign Medical Graduates? ☐ Yes ☐ No

ECFMG ○

List all of the following examinations you have taken and passed. (USMLE, FLEX, NBME, LMCC and/or STATE BOARDS)

Examination	**Date Passed** (mm/dd/yyyy)	Exams
		○
		○
		○
		○

MEDICAL EDUCATION

To verify your medical school meets the requirements set forth in Business and Professions Code section 2084, please use the links provided below.

Applicants must have received all of their medical school education from and graduated from: A U.S. or Canadian medical school accredited by the Liaison Committee for Medical Education (LCME), the Committee on Accreditation of Canadian Medical Schools, or the Commission on Osteopathic College Accreditation (http://lcme.org/directory/accredited-u-s-programs/).

- OR -

An international medical school that has been evaluated by the Educational Commission for Foreign Medical Graduates (ECFMG) or a foreign medical school listed on the World Federation for Medical Education (WFME) and the Foundation for Advancement of International Medical Education and Research (FAIMER) World Directory of Medical Schools joint directory or the World Directory of Medical Schools (https://search.wdoms.org/), or a foreign medical school that has been approved by the Board (http://www.mbc.ca.gov/Applicants/Medical_Schools/Schools_Recognized.aspx).

List each medical school that you have attended and the medical school of graduation.

Medical Education MED ○ Trans ○

Medical School	**Dates of Attendance**	School Code
Name	Start Date (mm/dd/yyyy)	
Mailing Address	End Date (mm/dd/yyyy)	

MED ○ Trans ○

		School Code
Name	Start Date (mm/dd/yyyy)	
Mailing Address	End Date (mm/dd/yyyy)	

Medical School of Graduation	**Title of Degree Awarded**	**Issue Date of Degree**	Diploma
		(mm/dd/yyyy)	○

Form L1B

Applicant Full Legal Name | **Date of Birth** (mm/dd/yyyy)

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ACGME, RCPSC, or CFPC ACCREDITED POSTGRADUATE TRAINING PROGRAMS

(Internship, Residency and Fellowship Programs)

Name & DOB ○

7. Have you participated in any ACGME-accredited postgraduate training programs in the United States, or RCPSC or CFPC-accredited postgraduate training in Canada? ☐ Yes ☐ No

PG Training Programs ○

List every program (internship, residency and fellowship) in which you have participated or are currently participating, regardless of whether the program was completed or any credit was granted.

Facility	Specialty	Dates of Training
Facility Name	Specialty	Start Date (mm/dd/yyyy)
City, State/Province		End Date (mm/dd/yyyy) ○
Facility Name	Specialty	Start Date (mm/dd/yyyy)
City, State/Province		End Date (mm/dd/yyyy) ○
Facility Name	Specialty	Start Date (mm/dd/yyyy)
City, State/Province		End Date (mm/dd/yyyy) ○

A "yes" response to questions 8 – 14 requires a signed and dated written explanation. Use the Explanation For Application Question (Form EXP) form to provide your explanation. When in doubt as to whether a postgraduate training issue should be disclosed, it is best to disclose the information on the application.

8. Have you ever received partial or no credit for a postgraduate training program? ☐ Yes ☐ No ○

9. Have you ever taken a leave of absence or break from your training? ☐ Yes ☐ No ○

10. Have you ever been terminated, dismissed, or expelled from a program? ☐ Yes ☐ No ○

11. Have you ever been placed on probation for any reason? ☐ Yes ☐ No ○

12. Have you ever been disciplined or placed under investigation? ☐ Yes ☐ No ○

13. Have you ever had any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason, which may include, but is not limited to, a corrective action plan, performance improvement plan, remediation plan, individual development plan, and any type of informal or progressive disciplinary or non-disciplinary action? ☐ Yes ☐ No ○

14. Have you ever had a postgraduate training program contract not be renewed or offered for a following year? ☐ Yes ☐ No ○

MEDICAL LICENSE

15. Have you ever held or do you currently hold a medical license in any U.S. state, U.S. territory, or Canadian province? ☐ Yes ☐ No

License ○

List medical license information for all licenses ever held below, including temporary, training, or provisional licenses. (If additional space is needed, please provide the required information on a separate sheet of paper).

U.S. State, U.S. Territory, or Canadian Province	License Number	Dates of Practice	
		(mm/dd/yyyy) to	(mm/dd/yyyy) ○
		(mm/dd/yyyy) to	(mm/dd/yyyy) ○
		(mm/dd/yyyy) to	(mm/dd/yyyy) ○
		(mm/dd/yyyy) to	(mm/dd/yyyy) ○

Form L1C

Applicant Full Legal Name _____ **Date of Birth** (mm/dd/yyyy) _____

ABMS CERTIFICATION

MBC USE ONLY
Name & DOB ○
ABMS

16. Are you currently certified by a Member Board of the American Board of Medical Specialties? ☐ Yes ☐ No

MALPRACTICE HISTORY

A "yes" response to question 17 requires a signed and dated written explanation. Use the Explanation For Application Question (Form EXP) to provide your explanation.

○
Malpractice History ○

17. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement, judgment, or arbitration? ☐ Yes ☐ No

DISCIPLINARY HISTORY

These questions refer to discipline by any hospital, military or public health service, state board, or other governmental agency of any U.S. state, U.S. territory, Canadian province, or foreign country. If in doubt as to whether discipline should be disclosed, it is best to disclose the information on the application.

A "yes" response to question 18-26 requires a signed and dated written explanation. Use the Explanation For Application Question (Form EXP) to provide your explanation.

Disciplinary History

18. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason? ☐ Yes ☐ No ○

19. Have you ever been denied a license to practice medicine or is any denial pending against you? ☐ Yes ☐ No ○

20. Have you ever had any license to practice medicine subjected to any disciplinary action or is any disciplinary action pending against any of your licenses to practice medicine? ☐ Yes ☐ No ○

21. Have you ever surrendered a license to practice medicine or have you ever had any license to practice medicine revoked, suspended, or placed on probation? ☐ Yes ☐ No ○

22. Have you ever had any license to practice medicine subjected to any action including, but not limited to, informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation? ☐ Yes ☐ No ○

23. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital? ☐ Yes ☐ No ○

24. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action or is any disciplinary action pending against your hospital or staff privileges? ☐ Yes ☐ No ○

25. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed? ☐ Yes ☐ No ○

26. Have you ever had any healing arts license or certificate disciplined by any state, federal, or foreign jurisdiction? ☐ Yes ☐ No ○

Form L1D

Applicant Full Legal Name _____ **Date of Birth** (mm/dd/yyyy) _____

PRACTICE IMPAIRMENT OR LIMITATIONS

Please note that an affirmative answer to any of the questions below will not automatically disqualify you from licensure. The Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are eligible for licensure. Please note that a limited practice license may be available. Refer to the Application Information for a Limited Practice License for further information.

A "yes" response to question 27-29 requires a signed and dated written explanation. Use the Explanation for Application Question (Form EXP) to provide your explanation.

Limitations

27. Are you currently enrolled in, or participating in any drug, alcohol, or substance abuse recovery program or impaired practitioner program? ☐ Yes ☐ No ○

28. Do you currently have any condition (including, but not limited to emotional, mental, neurological or other physical, addictive, or behavioral disorder) that impairs your ability to practice medicine safely? ☐ Yes ☐ No ○

29. Do you currently have any other condition that impairs or limits your ability to practice medicine safely? ☐ Yes ☐ No ○

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PHOTOGRAPH AND NOTICE

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. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensing per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act.

Reviewed L1A-L1F ○

Staff Initials & Date

Photo ○

DECLARATION

Applicant Name & DOB ○

The applicant, Full Legal Name (First, Middle, Last, Suffix) _____, Date of Birth (mm/dd/yyyy _____

being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; and that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, FALSIFICATION, OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

Applicant Signature & Date ○

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

Form L1E