



Application for a Physician's and Surgeon's License

TYPE OF APPLICATION

MBC USE ONLY

(Select One)

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

(Select One)

Physician's and Surgeon's Certificate Previously Licensed Limited Practice License

(Optional)

App Type

PRIORITY REVIEW AND EXPEDITED LICENSURE

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

- 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

Priority Review

PERSONAL INFORMATION

Full Legal Name

Full Last Name	First Name	Middle Name	Suffix
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Legal Name

Other Names/Alias

Date of Birth

DOB

SSN/ITIN

- Social Security Number or Individual Taxpayer Identification Number

- Gender
- Female
 - Male
 - Non-Binary

Gender

Telephone Numbers

(Include area code)

Primary	Cell	Work
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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.

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

AOR

Confidential Address

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

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

Conf. Address

- Are you a registered sex offender? Yes No
- Have you served or are you currently serving in the United States Armed Forces? Yes No
- 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

Sex Offender

Military Service

Spouse or Partner

MBC USE ONLY

Cashiering

Modifier

School Code

Form **L1A**

Applicant

Full Legal Name

Date of Birth

(mm/dd/yyyy)

PREVIOUS APPLICATION OR LICENSE

MBC USE ONLY

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 School

Dates of Attendance

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

Medical Education
MED Trans
School Code

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

MED Trans
School Code

Medical School of Graduation

Title of Degree Awarded

Issue Date of Degree

		(mm/dd/yyyy)
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Diploma

Form **L1B**

Applicant

Full Legal Name

Date of Birth

(mm/dd/yyyy)

ACGME, RCPSC, or CFPC ACCREDITED POSTGRADUATE TRAINING PROGRAMS
(Internship, Residency and Fellowship Programs)

MBC USE ONLY

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)



Applicant

Full Legal Name

Date of Birth

(mm/dd/yyyy)

ABMS CERTIFICATION

MBC USE ONLY

Name & DOB

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

ABMS

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.

- 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

Limitations

PHOTOGRAPH AND NOTICE

MBC USE ONLY

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

Full Legal Name (First, Middle, Last, Suffix)

Date of Birth (mm/dd/yyyy)

Applicant Name & DOB

The applicant, _____, _____, 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**