Medical Board of California

Certificate of Completion of CODA Postgraduate Training

Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
Fax: (916) 263-2487
www.mbc.ca.gov

MBC USE ONLY

APPLICANT INFORMATION

Note: To qualify for a physician's and surgeon's license in California after receiving a medical degree from a combined medical and dental program, the applicant must complete a minimum of 36 months of Board-approved postgraduate training to include not less than 24 months of oral and maxillofacial surgery postgraduate training accredited by the Commission on Dental Accreditation (CODA) and 12 months of ACGME-accredited postgraduate training. In addition to this form, a Certificate of Completion of ACGME/RCPSC/CFPC Postgraduate Training (Form PTA-PTB) is required to verify the 12 months of ACGME/RCPSC/CFPC accredited training.

Applicant Information

Legal Name

Full Last Name	First Name	Middle Name	Suffix

Date Of Birth (mm/dd/yyyy)	U.S. SSN or ITIN (Last 4 digits)	Medical School of Graduation

PROGRAM DIRECTOR TO COMPLETE CODA TRAINING INFORMATION

Verified Program Information

Facility Name

Facility Address

Specialty Oral and Maxillofacial Surgery

Dates of Clinical Training

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)

UNUSUAL CIRCUMSTANCES

Program Director: Provide a signed and dated letter of explanation, including dates, for any "yes" response to questions # 1-7. The explanation must be provided on program letterhead and submitted directly to the Board with this form.

1. Did the applicant receive partial or no credit during his/her postgraduate training? ☐ Yes ☐ No
2. Did the applicant ever take a leave of absence or break from his/her training? ☐ Yes ☐ No
3. Was the applicant ever terminated, dismissed, or expelled? ☐ Yes ☐ No
4. Was the applicant ever placed on probation? ☐ Yes ☐ No
5. Was the applicant ever disciplined or placed under investigation? ☐ Yes ☐ No
6. Were any limitations or special requirements placed upon the applicant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason? ☐ Yes ☐ No
7. Did the program decline to renew or offer the applicant postgraduate training program contract for the following year? ☐ Yes ☐ No

Form CODA1

APPLICANT INFORMATION

Legal Name

Full Last Name	First Name	Middle Name	Suffix

MBC USE ONLY

Applicant Name ○

ATTENTION: PROGRAM DIRECTOR

Do not sign and date this form prior to the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the applicant has satisfactorily completed a period of accredited postgraduate training at this facility and that the applicant has acquired the skills and qualifications necessary to safely assume the unrestricted practice of medicine in this state. Only the program director may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

The program director signing this form is formally certifying and documenting under penalty of perjury that the applicant received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to satisfactory performance. The program director is attesting to the fact that the applicant has acquired the skills and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Verified PD Staff Initials & Date

I hereby declare under penalty of perjury under the laws of the State of California that all of the information contained on these forms is true and correct. I further certify that the training program is accredited by CODA to offer the type and level of training completed by the applicant named on this form, and the applicant was trained in a CODA slotted program position.

_____

PRINTED NAME OF PROGRAM DIRECTOR

Program Director's Signature & Date ○

_____ _____

SIGNATURE OF PROGRAM DIRECTOR **DATE**

Note: If a program seal is not available, the program director shall also sign in the section below in the presence of a notary public.

SIGNATURE OF PROGRAM DIRECTOR: _____

(SIGN FULL NAME IN PRESENCE OF NOTARY)

Program Director's Signature ○

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 _____,

by, Print Program Director's Name _____

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

(PROGRAM or NOTARY SEAL)

Notary Signature & Seal ○

Program Seal ○

_____

SIGNATURE OF NOTARY PUBLIC

Note: The completed form must be submitted directly from the program through the Board's Direct Online Certification Submission (DOCS) portal or by mail to be acceptable.

Form **CODA2**