**Medical Board of California**

# Postgraduate Training License Enrollment Form

If the trainee moves, or transfers to another program, is terminated, resigns, or takes a leave of absence, a Program Status Update/Change Form is required.

**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

**Legal Name**

| Full Last Name | First Name | Middle Name | Suffix |
|---|---|---|---|
| | | | |

Applicant Information ○

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

## PROGRAM DIRECTOR TO COMPLETE ACGME TRAINING INFORMATION

**Facility Name**

**Facility Address**

Verified Program Information ○

**Specialty** — Required

**ACGME 10-digit Program#** https://apps.acgme.org/ads/Public — Required

**Dates of Training** — Start Date (mm/dd/yyyy) — End Date (or anticipated completion date): (mm/dd/yyyy) ○

## PROGRAM DIRECTOR OFFICIAL CERTIFICATION

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. The person who signs this form may not be related to the applicant by blood, marriage, or adoption. **If the trainee takes a leave of absence, resigns, exits, or transfers to another program, please submit a Program Status Update/Change Form.**

Verified PD ○

*I hereby declare under penalty of perjury under the laws of the State of California that the information contained on this form is true and correct. I further certify that the training program is accredited by the ACGME to offer the type and level of training to the above named applicant and that the applicant is actively participating in a slotted position in an accredited ACGME postgraduate training program.*

Staff Initials & Date:

**PRINTED NAME OF PROGRAM DIRECTOR**

**SIGNATURE OF PROGRAM DIRECTOR** — **DATE**

Program Director's Signature & 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.

**SIGNATURE OF NOTARY PUBLIC**

(PROGRAM or NOTARY SEAL)

Notary Signature & Seal ○

Program Seal ○

**Note: The completed form must be submitted directly from the program to the Board to be acceptable**

Form EF