



Medical Board of California

Postgraduate Training License Enrollment Form

The current program director must complete and submit Form EF verifying that the applicant for a postgraduate training license is currently enrolled or will be enrolled in a California ACGME-accredited postgraduate training program.

Licensing Program

2005 Evergreen Street, Suite 1200

Sacramento, CA 95815-5401

Phone: (916) 263-2382

www.mbc.ca.gov

APPLICANT INFORMATION

MBC USE ONLY

Medical School Graduate: (Check One)

☐ U.S. or Canadian

☐ International

Full Legal Name

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

Medical School
☐

Applicant Information
☐

Date of Birth U.S. SSN or ITIN PTL # Medical School of Graduation

| | | | |
|--------------|-----------------|-----------------|--|
| (mm/dd/yyyy) | (Last 4 digits) | (if applicable) | |
|--------------|-----------------|-----------------|--|

PROGRAM DIRECTOR TO COMPLETE ACGME TRAINING INFORMATION

Note: The start date of clinical training should not include time spent in non-clinical orientation. A signed and dated letter of explanation listing detailed information including dates is required if the anticipated end date of the program is longer than what is reflected on ACGME's website. The postgraduate training license will be valid for 36 months, while enrolled in a California ACGME-accredited postgraduate training program.

Facility Name

Required

Facility Address

Required

Specialty

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

Verified Program Information
☐

Specialty/ACGME #
☐

Dates of Clinical Training

| | |
|-------------------------|-----------------------------------|
| Start Date (mm/dd/yyyy) | Anticipated End Date (mm/dd/yyyy) |
|-------------------------|-----------------------------------|

Dates of Training
☐ ☐

Program Type

☐ Transitional

☐ Preliminary/Internship

☐ Categorical

☐ Fellowship

☐

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

The program director or the designated institutional official (DIO) must sign this form. If the program director or the DIO is delegating the signature authority to another person, attach evidence of that delegation 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 resident moves, transfers to another program, is terminated, resigns, or takes a leave of absence resulting in a change to the PTL expiration date, the program director must submit a [Program Status Update/Change Form](#) directly to the Board within 30 days.**

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/will be participating in a slotted position in an ACGME-accredited postgraduate training program during the dates listed above.

Staff Initials & Date

PRINTED NAME OF PROGRAM DIRECTOR OR DIO

SIGNATURE OF PROGRAM DIRECTOR OR DIO
(Signature stamps are not acceptable)

DATE

Program Director/
DIO's
Signature &
Date
☐

Note: The program must submit the completed form directly to the Board through the Board's Direct Online Certification Submission (DOCS) portal if the resident has an open application with the Board to be acceptable

Form EF