



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.

APPLICANT INFORMATION

MBC USE ONLY

Medical School Graduate: (Check One) U.S. or Canadian International

Medical School

Full Legal Name

Full Last Name	First Name	Middle Name	Suffix
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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 includes research years and/or the program length is longer than what is reflected on ACGME's website. The postgraduate training license will only be valid during research years that occur in the middle of the clinical training required for licensure AND if the resident remains enrolled in the ACGME-accredited program when conducting research.

Facility Name Required

Verified Program Information

Facility Address Required

Specialty Required

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

Specialty/ACGME #

Dates of Clinical Training

Start Date (mm/dd/yyyy)	Anticipated End Date (mm/dd/yyyy)
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Dates of Training

Program Type Transitional Preliminary/Internship Categorical

Will the resident be completing research during training that requires them to take a break from training, a leave of absence, change the anticipated clinical training end date, and/or no longer be enrolled in the program? Yes No

If "Yes", please complete the [Research Period Questionnaire, Form RES1-RES2](#).

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

