



Application for a Postgraduate Training License

MBC USE ONLY

TYPE OF APPLICATION

(Check One)

U.S. or Canadian Medical School Graduate

International Medical School Graduate

Application Type

PERSONAL INFORMATION

Legal Name

Full Last Name	First Name	Middle Name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Legal Name

Other Names/Alias

Date Of Birth

DOB

SSN/ITIN

Social Security Number or
 Individual Taxpayer Identification Number

Gender Female
 Male

Gender

Telephone Numbers (Include area code)

Primary	Cell	Work
<input type="text"/>	<input type="text"/>	<input type="text"/>

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)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
City	State/Province	Zip/Postal Code	Country
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
City	State/Province	Zip/Postal Code	Country
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Conf. Address

1. Have you ever filed an application for a Postgraduate Training License in California? Yes No

PTL

2. Are you currently serving, or have you previously served, in the military? Yes No

Military

EXAMINATIONS

3. 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 or LMCC)

Examination	Date Passed (mm/dd/yyyy)
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Exams

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Cashiering

Modifier

School Code

Form **PTL1**

Applicant

Full Legal Name

Date of Birth

(mm/dd/yyyy)

MEDICAL EDUCATION

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List each medical school that you have attended and the medical school of graduation.

Medical School

Date of Attendance

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

Name & DOB

Medical Education
MED Trans

School Code

MED Trans

School Code

Medical School of Graduation

Title of Degree Awarded

Issue Date of Degree

	(mm/dd/yyyy)
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Diploma

ACGME ACCREDITED POSTGRADUATE TRAINING PROGRAMS

(Internship, Residency and Fellowship Programs)

List the ACGME accredited postgraduate training program where you are enrolled and will be participating in California.

Facility Specialty Dates of Training

Facility Name	Specialty	Start Date (mm/dd/yyyy)
City, State/Province		End Date (mm/dd/yyyy)

List every ACGME, RCPSC, or CFPC accredited program (internship, residency and fellowship) which you have participated in, 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)

A "yes" response to questions 4 – 10 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.

- 4. Have you ever received partial or no credit for a postgraduate training program? Yes No
- 5. Have you ever taken a leave of absence or break from your training? Yes No
- 6. Have you ever been terminated, dismissed, or expelled from a program? Yes No
- 7. Have you ever been placed on probation for any reason? Yes No
- 8. Have you ever been disciplined or placed under investigation? Yes No
- 9. Have you ever had any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason? Yes No
- 10. Have you ever had a postgraduate training program contract not be renewed or offered for a following year? Yes No

Form **PTL2**

Applicant

Full Legal Name

Date of Birth

(mm/dd/yyyy)

MEDICAL LICENSE

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List medical license information for all licenses ever held below. Do not list temporary, training, or provisional licenses.

Name/DOB

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)

DISCIPLINARY HISTORY

These questions refer to discipline by any hospital, military or public health service, licensing 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 11-19 requires a signed and dated written explanation. The [Explanation For Application Question \(Form EXP\)](#) may be used to provide your explanation.

- 11. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason? Yes No

- 12. Have you ever been denied a license to practice medicine or is any denial pending against you? Yes No

- 13. 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

- 14. 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

- 15. 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

- 16. 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

- 17. Have you ever resigned from a medical staff position in lieu of disciplinary or administrative action or is any disciplinary action pending against your hospital or staff privileges? Yes No

- 18. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed? Yes No

- 19. Have you ever had any healing arts license or certificate disciplined by another state or federal territory? Yes No

Applicant

Full Legal Name

Date of Birth

(mm/dd/yyyy)

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CRIMINAL RECORD HISTORY

Applicants who answer "NO" to the questions below, but have a previous conviction or plea, may have their application denied for knowingly falsifying the application. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application. Name/DOB
○

For each conviction, you must submit certified copies of the arresting agency report, certified copies of the court documents (court docket) and a signed and dated descriptive explanation of the circumstances surrounding the conviction (i.e., dates and location of the incident and all circumstances surrounding the incident). If the documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is required. In addition, you may submit evidence of rehabilitation.

A "yes" response to question 20-23 requires a signed and dated written explanation. The [Explanation For Application Question \(Form EXP\)](#) may be used to provide your explanation.

20. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in the United States, its territories, or a foreign country?

This includes every citation, infraction, misdemeanor and/or felony, including traffic violations. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b), (c), (d), (e), or section 11360(b) which are two years or older should NOT be reported. Convictions that were later expunged from the record of the court or set aside pursuant to section 1203.4 of the California Penal Code or equivalent non-California law MUST be disclosed.

Yes No ○

21. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357(b), (c), (d), (e), or section 11360(b) which are two years or older, have you had a charge or conviction that was set aside or later expunged from the record of the court?

Yes No ○

22. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?

Yes No ○

23. Are you a registered sex offender?

Yes No ○

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 24-26 requires a signed and dated written explanation. The [Explanation For Application Question \(Form EXP\)](#) may be used to provide your explanation.

24. Are you currently enrolled in, or participating in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?

Yes No ○

25. 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 ○

26. Do you currently have any other condition that impairs or limits your ability to practice medicine safely?

Yes No ○

PHOTOGRAPH AND NOTICE

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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 PTL1-5



Staff Initials & Date

Photo



DECLARATION

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

Date of Birth (mm/dd/yyyy)

The applicant,

Applicant Name & DOB



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:** _____

NOTARY SECTION

SIGNATURE OF APPLICANT: _____ (SIGN LEGAL NAME IN THE PRESENCE OF NOTARY)

Applicant 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____,

Print Applicant's Legal Name

by,

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

(NOTARY SEAL)

Applicant Name & Notary Date



Notary Signature & Seal



SIGNATURE OF NOTARY PUBLIC

Form **PTL5**