Physician's and Surgeon's - Initial Application - Introduction

Review the Application for a Physician's and Surgeon's License Information & Checklist for a detailed guide of all license application requirements.

Previously Licensed in California: If you have previously held a California Physician's and Surgeon's License and want to reinstate your license, please cancel this application and refer to the Physicians and Surgeons Previously Licensed in California "Apply" page on the Board's website for more information.

Limited Practice License: If applying for a Limited Practice License, please review the Physician's and Surgeon's Limited Practice License application page on the Board's website for more information. Complete the Limited Practice License, Form LPL, and submit via mail or attach with this application on the Attachments page.

Postgraduate Training License Holder: If you hold or previously held a California Postgraduate Training License, please cancel this application and complete the online Application to Transition from a PTL to a Physician's and Surgeon's License.

This application requires you to provide detailed information. Each page of this online application will time out after approximately 15 minutes. To help with the completion of the application, review the "Application Submission Methods" section of the Application for a Physician's and Surgeon's License Information & Checklist to complete each page. Note, after 15 minutes of inactivity the system will time out.

As an applicant, **you are personally responsible for all information disclosed on the application**, including any responses that may have been completed on your behalf or information provided to you by others. The Board may deny your application based upon omission, falsification or misrepresentation of any item or response on the application or any attachment. The Board considers violations of an ethical nature to be a serious breach of professional conduct.

For minimum requirements, information, instructions, and forms, please see the Physician's and Surgeon's License application page on the Board's website.

Press "Next" to continue.

To save and exit this application, click on the "Cancel" button.

Physician's & Surgeon's Initial License Application – P&S Initial License Renewal Requirement

- As a requirement of the initial license renewal, the licensee must provide verification of receiving credit for 36 months of Board-approved postgraduate training.
- If your training was part of the MD-integrated Oral and Maxillofacial Surgery (OMFS) postgraduate training program, then you must provide evidence of receiving credit for at least 24 months of postgraduate training accredited by the Commission on Dental Accreditation (CODA) to meet the initial renewal requirement. CODA-accredited postgraduate training must be part of an oral and maxillofacial surgery postgraduate training program after receiving a medical degree from a combined dental and medical degree program. The Board must receive this documentation no later than the initial license expiration date.
- Proof of the required postgraduate training program must be mailed to the Board and postmarked no later than the initial license expiration date to be considered by the Board. Please note that your license will be automatically placed in delinquent status pending review if you do not submit proof of the required postgraduate training within sufficient time for the Board to process it before your license expiration date. An initial license is issued for a period of two years and 60 days to allow additional time to provide the Board the required documents. After the first renewal, the license is only valid for a two-year period until the next renewal.
- You are not required to provide this documentation of postgraduate training after the issuance of your P&S license if you:
  - Provided verification of successfully completing 36 months of postgraduate training during the application process (you will be notified by the Board once this requirement has been completed),

    -OR-

  - Are being licensed pursuant to Business and Professions Code (BPC) sections 2135, 2135.5, 2151, or 2428, or if you used experience under a BPC section 2113 permit to qualify for a P&S license.

Next Cancel

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Physician's and Surgeon's - Initial Application - Information Privacy Act

NOTICE: All items in this application are mandatory; none are voluntary.

The Licensing Program of the Medical Board of California requests this information to determine your eligibility for a P&S License. The Board may reject your application as incomplete if you fail to provide the requested information. The Board will use the information you provide to verify your identity and determine your qualifications for licensure pursuant to section 2080 of the California Business and Professions Code (BPC), which authorizes the collection of this information.

The Licensing Program Chief is the custodian of records. Access to records by the individual to whom they pertain may be obtained under the Information Practices Act, Civil Code section 1798.17, by contacting the Board.

The Board may transfer the provided information on your application to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies.

Disclosure of your United States Social Security Number (SSN) or your Individual Taxpayer Identification Number (ITIN) is mandatory prior to the issuance of a license. Section 30 of the Business and Professions Code authorizes collection of your SSN or ITIN. Section 31(e) of the Business and Professions Code allows the State Board of Equalization and the Franchise Tax Board to share taxpayer information with the Board. A license issued by the Board may be suspended if a state tax obligation is not paid. Reporting a number on your application that is not your SSN or ITIN may be grounds for denial of licensure.

Press "Agree" to continue.

To save and exit this application, click on the "Cancel" button.

Agree Cancel

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Physician's and Surgeon's - Initial Application - Function Suitability

Question #1

Applicants must have received all medical school education, and graduated from, a medical school approved by the Medical Board of California:

1. U.S. or Canadian medical school accredited by the Liaison Committee for Medical Education (LCME), the Committee on Accreditation of Canadian Medical Schools, or the Commission on Osteopathic College Accreditation.

   http://lcme.org/directory/accredited-u-s-programs/

   -OR-

2. An international medical school which has been evaluated by the Educational Commission for Foreign Medical Graduates (ECFMG), the international medical school is listed on the World Federation for Medical Education (WFME), the Foundation for Advancement of International Medical Education and Research (FAIMER) World Directory of Medical Schools joint directory, or the World Directory of Medical Schools.

   https://search.wdoms.org/

   -OR-

3. An international medical school approved by the Medical Board of California (Board).

Question #2

To meet the postgraduate training requirement, you must have received either a minimum of 12-months credit (for U.S. or Canadian medical school graduates) OR 24 months credit (for international medical school graduates) of board-approved postgraduate training. All postgraduate training must be accredited by the Accreditation Council for Graduate Medical Education (ACGME), Royal College of Physicians and Surgeons of Canada (RCPSC), and/or College of Family Physicians of Canada (CFPC) (RCPSC and CFPC training must be completed in Canada).

Question #3

If you have previously held a Physician's and Surgeon's License issued by the Medical Board of California and want to reinstate your license, please cancel this application and refer to the Physician and Surgeon Previously Licensed application page on the Board's website for more information.

Press "Previous" to return to the previous section.

Answer the questions and press "Next".

To save and exit this application, click on the "Cancel" button.

Question	Answer
Did you receive all of your medical school education and graduate from a medical school approved by the Board?	○ Yes ○ No
Have you received either a minimum of 12-months credit (for U.S. or Canadian medical school graduates) or are currently enrolled in your first year of residency; OR 24-months credit (for international medical school graduates) or are currently enrolled in your second year of Board-approved training; OR Have you completed at least one year of approved postgraduate training and are certified by a specialty board approved by the American Board of Medical Specialties?	○ Yes ○ No
Have you previously held a Physician's and Surgeon's License in California?	○ Yes ○ No

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Reduced Initial Licensing Fee
If you are enrolled in an ACGME, RCPSC, CFPC, or CODA-accredited training program, you may be eligible for a 50 percent reduction of the initial license fee. To be eligible for the reduced license fee, your program director must document your enrollment by completing a Current Postgraduate Training Verification, Form CTV.

Priority Review and Expedited Licensure
Review additional requirements on qualifying for Priority Review or Expedited Licensure. The Board will NOT expedite review of your application nor the licensure process if any of the required documents are missing or the documentation does not verify qualification under the requirements.

Military Honorable Discharge Requirements
In order to expedite the review of your application, attach a copy of the following documentation on the attachments page of this application:

- DD214 or other supporting documentation.

Military Spouse or Domestic Partner Requirements
In order to expedite the review of your application, attach a copy of the following documentation on the attachments page of this application.

- Evidence that you are married to, in a domestic partnership, or in other legal union with an active-duty member of the United States Armed Forces who is assigned to a duty station in California under official active-duty military orders;
- Evidence of your spouse's or domestic partner's official assignment to a duty station in California; and
- Evidence that you hold a current medical license in another state, district, or territory of the United States.

NOTE: If the supporting documents are not received and/or you do not qualify for the fee waiver, then you must submit the required fees by check for the Board to continue to process your application.

Practice in Medically Underserved Area or Population Requirements
In order to expedite the review of your application, attach a copy of the following documentation on the attachments page of this application.

- A signed and dated letter from the applicant confirming their acceptance of employment in California to provide medical services to a formally designated underserved area and/or population; and
- A signed and dated letter from the applicant's prospective employer confirming their offer of prospective employment to provide medical services to a formally designated underserved area and/or population in California. The letter must include the proposed employment start date, the name and address of the facility(s) where you will provide medical services, and the medical services you will provide.

Admitted to the United States as a Refugee, Granted Asylum, or Have a Special Immigrant Visa Status (SIV)
In order to expedite review of your application, attach a copy of the applicable documentation on the attachments page of this application if you were admitted to the United States as a refugee, were granted asylum, or have a special immigrant visa and were granted a status:

- Form I-94, Arrival/Departure Record, with an admission class code such as "RE" (Refugee) or "AY" (Asylee) or other information designating the person a refugee or asylee.
- Special immigrant visa that includes the "SI" or "SQ".
- Permanent Resident Card (Form I-551), commonly known as a "Green Card", with a category designation indicating that the person was admitted as a refugee or asylee.
- An order from a court of competent jurisdiction or other documentary evidence that provides reasonable assurance that the applicant qualifies for expedited licensure.

Answer the questions and press "Next" to continue.

Press "Previous" to return to the previous section.

To save and exit this application, click on the "Cancel" button.

Are you currently enrolled in an ACGME, RCPSC, CFPC, or CODA-accredited postgraduate training program in the United States or Canada?	No
Are you applying with an Individual Taxpayer Identification Number (ITIN)?	No
Have you served or are you currently serving in the United States Armed Forces?	No
Are you requesting the Board to expedite review of your application as a spouse or domestic partner of, or other legal union with, an active-duty member of the United States Armed Forces?	No
Are you requesting expediting of this application for honorably discharged members of the U.S. Armed Forces?	No
Are you requesting the Board to expedite review of your application to practice in a medically underserved area or population?	No
Were you admitted to the United States as a Refugee, granted asylum, or have a Special Immigrant Visa status?	No
Are you requesting a temporary license as a spouse to, in a domestic partnership or in other legal union with, an active-duty member of the United States Armed Forces who is assigned to a duty station in California under official active-duty military orders?	No
Are you requesting expediting of this application as you will be providing abortion services as defined in Section 123464 of the Health and Safety Code?	No
Pursuant to Business and Professions Code Section 115.4, beginning July 1, 2024, the board/bureau shall expedite the initial licensure process for an applicant who is an active duty member of the US Armed Forces and enrolled in the US Department of Defense SkillBridge program. Do you request expediting of your application under this authority? (If you select YES, you must attach documentation of enrollment to this application.)	No

Individual Taxpayer Identification Number
Business and Professions Code section 30 authorizes the Board to collect either your Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN). An ITIN is a tax processing number issued by the Internal Revenue Service. The IRS issues ITINs to individuals who are required to have a U.S. taxpayer identification number but who do not have, and are not eligible to obtain, an SSN from the Social Security Administration.

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Temporary License for Spouses of Active-Duty Member of the United States Armed Forces:

The Board may issue a Temporary Physician's and Surgeon's License to an applicant who is married to, or in a domestic partnership or other legal union with an active-duty member of the United States Armed Forces who is assigned to a duty station in California under official active-duty military orders. The applicant must hold a current, active, and unrestricted license in another state, district, or territory of the United States in the same profession or vocation for which the applicant seeks a temporary license. Please attach the following documentation to the attachments page of this application:

- Evidence that you are married to, or in a domestic partnership or other legal union with, an active-duty member of the Armed Forces of the United States who is assigned to a duty station in California under official orders;
- Evidence of your spouse's or domestic partner's official assignment to a duty station in California; and
- Evidence that you hold current medical license in another state, district or territory of the United States.

For minimum requirements, information, instructions, and forms, please visit the Physician and Surgeon Temporary License page on the Board's website.

ABORTION SERVICES

An applicant who demonstrates they intend to provide abortions within the scope of practice of their license may qualify for expedited application processing, if they provide the Board with the documentation identified below. An "abortion" is any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.

To qualify, you must submit the following documentation with your application:

- A letter declaring your intent to provide abortions; and,
- A letter from an employer or health care entity indicating that you have accepted employment or entered into a contract to provide abortions. This letter must include:

1. The starting date;
2. The location where you will be providing abortions; and,
3. That you will be providing abortions within the scope of practice of your applicable license, in accordance with Business and Professions Code Sections 2253, 2725.4, and 3502.4.

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Physician's and Surgeon's - Initial Application - Name and Personal Details

You must enter your full legal name including middle name(s) and suffix if applicable.

Pursuant to Business and Professions Code section 30, you MUST provide either your Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN). The number you provide will be used for purposes related to tax enforcement, compliance with a judgment or order for child or family support in accordance with Family Code section 17520, or for verification of licensure or examination status when a reciprocity agreement or comity exists between that state and California. If you fail to disclose your SSN or ITIN, your application will not be processed and you will be reported to the Franchise Tax Board, which may assess a penalty against you.

The Board may disclose this application and the information contained herein, except for your SSN or ITIN, pursuant to a request made under the California Public Records Act.

Press "Previous" to return to the previous screen.

Enter your personal details and Press "Next" to continue.

To save and exit this application, click on the "Cancel" button.

* First Name:	
Middle Name:	
* Last Name:	
Alias:	
Suffix:	
* U.S. SSN/ITIN:	
* Birth Date:	(mm/dd/yyyy)
* Gender:	

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Physician's and Surgeon's - Initial Application - Address Detail Summary

- **Address of Record (AOR) (Required):** The AOR is mandatory and is the primary address the Board uses to contact you regarding issues specific to this license (application, renewal, etc.). Upon licensure, **this address will become public information.**

NOTE: If you are using a Post Office (PO) Box for your "Address of Record" (AOR), you **must** also include a "Confidential Address".

- **Confidential Address (Optional):** This is a secondary address that is required if you listed a PO Box as your address of record. You may not use the street address of a private mailbox service as a confidential street address. Even if you provide a street address as your address of record, you may provide a second street address that will remain confidential. **The Board will NOT disclose this information to the public.**

Add the required AOR to continue.

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The following address types are mandatory. Please add these in order to continue.

- Address of Record

Press "Add" to add an optional or mandatory address.

Press "Previous" to return to the previous section.

Press "Next" when finished adding/changing addresses.

To save and exit this application, click on the "Cancel" button.

Please note, the 'Address of Record' will be disclosed to the public.

Previous | Next | Add | Cancel

Physician's and Surgeon's - Initial Application - Add Address Details - Select Address Type

- **Address of Record (AOR) (Required):** The AOR is mandatory and is the primary address the Board uses to contact you regarding issues specific to this license (application, renewal, etc.). Upon licensure, **this address will become public information.**

NOTE: If you are using a Post Office (PO) Box for your "Address of Record" (AOR), you **must** also include a "Confidential Address".

- **Confidential Address (Optional):** This is a secondary address that is required if you listed a PO Box as your address of record. You may not use the street address of a private mailbox service as a confidential street address. Even if you provide a street address as your address of record, you may provide a second street address that will remain confidential. **The Board will NOT disclose this information to the public.**

Add the required AOR to Continue.

Select an address type from the drop-down list and press "Next".

Press "Back" to return to the Address Detail Summary Screen.

* Address Type:

NOTE: the "Address of Record" will be disclosed to the public.

Next | Back

* Address Type:

NOTE: the "Address of Record" will b

- Address of Record
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Physician's and Surgeon's - Initial Application - Add Address Details

Enter your contact information below and press "Continue" when done.

Enter/Update your address, phone number and email address and press "Continue" when done.

Press "Back" to return the previous screen.

Address of Record

* Address Line 1:

Address Line 2:

Address Line 3:

* City:

* State: California

* Zip Code:

* Country: United States

* Primary Phone Number:

Extension:

* Email:

* Confirm Email:

Work Phone:

Home Phone:

When entering a non-U.S address, please select "Out of Country State" in the "State" drop-down menu. Then, enter your postal code in the format as required by your country's postal agency.

Continue | Back

Your email address needs to be verified before continuing with the application.
Please go to your email and click the link to verify your email address.

*Logged in as **MBCTest, Violet*** Update Profile | Logoff | Contact Us

Email Address Successfully Updated

Email Address has been successfully updated.

Please close this browser tab and continue with your application.

Email Address Updated to [redacted]

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Physician's and Surgeon's - Initial Application - Address Detail Summary

- **Address of Record (AOR) (Required):** The AOR is mandatory and is the primary address the Board uses to contact you regarding issues specific to this license (application, renewal, etc.). Upon licensure, **this address will become public information.**

NOTE: If you are using a Post Office (PO) Box for your "Address of Record" (AOR), you **must** also include a "Confidential Address".

- **Confidential Address (Optional):** This is a secondary address that is required if you listed a PO Box as your address of record. You may not use the street address of a private mailbox service as a confidential street address. Even if you provide a street address as your address of record, you may provide a second street address that will remain confidential. **The Board will NOT disclose this information to the public.**

Add the required AOR to continue.

Press "Add" to add an optional or mandatory address.
Press "Previous" to return to the previous section.
Press "Next" when finished adding/changing addresses.
To save and exit this application, click on the "Cancel" button.

License Specific Addresses

Address of Record

Address: [redacted]
Primary Phone Number: [redacted]
Email: [redacted]
Work Phone:
Home Phone:

Please note, the 'Address of Record' will be disclosed to the public.

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Physician's and Surgeon's - Initial Application - General Information - Information

Press "Previous" to return to the previous section.
Enter appropriate details and press "Next" to continue.
To save and exit this application, click on the "Cancel" button

* Are you a registered sex offender? ○ Yes ○ No

Previous Next Cancel

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Press "Previous" to return to the previous section.
Enter appropriate details and press "Next" to continue.
To save and exit this application, click on the "Cancel" button

* Have you ever filed an application for a Physician's and Surgeon's License or other license in California that has been withdrawn, abandoned, or denied? (If "Yes", attach the signed and dated Form EXP to the attachment page at the end of this application.) ○ Yes ○ No

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Physician's and Surgeon's - Initial Application - Examinations - Information

To meet the requirements for licensure, you must have taken and passed all steps of the United States Medical Licensing Examination (USMLE), or other acceptable examinations per Section 1328 of Title 16 of the California Code of Regulations.

Each examination agency must submit an electronic, official examination history report directly to the Board or submitted with the Federation Credentials Verification Service (FCVS) to be acceptable.

List all of the examinations you have taken and passed: **(USMLE, FLEX, NBME, LMCC and/or STATE BOARDS).**

Press the "Edit" link to edit the record.

Press the "Remove" link to remove the record.

Press "Add" to add a new record.

Press "Previous" to return to the previous section.

Enter appropriate details and press "Next" to continue.

To save and exit this application, click on the "Cancel" button

Examination	Date Passed (mm/dd/yyyy)

Add Previous Next Cancel

Physician's and Surgeon's - Initial Application - Examinations - Add

To meet the requirements for licensure, you must have taken and passed all steps of the United States Medical Licensing Examination (USMLE), or other acceptable examinations per Section 1328 of Title 16 of the California Code of Regulations.

Each examination agency must submit an electronic, official examination history report directly to the Board or submitted with the Federation Credentials Verification Service (FCVS) to be acceptable.

List all of the examinations you have taken and passed: **(USMLE, FLEX, NBME, LMCC and/or STATE BOARDS).**

Press "Next" to save this record and continue.

Press "Cancel" if you do not want to save your changes.

* Examination:

* Date Passed: (mm/dd/yyyy)

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Physician's and Surgeon's - Initial Application - Medical Education - Information

You must have received all your medical school education, and graduated from, a medical school approved by the Medical Board of California (Board):

1. U.S. or Canadian medical school accredited by the Liaison Committee for Medical Education (LCME), the Committee on Accreditation of Canadian Medical Schools, or the Commission on Osteopathic College Accreditation.

   http://lcme.org/directory/accredited-u-s-programs/

   -OR-

2. An international medical school, which has been evaluated by the Educational Commission for Foreign Medical Graduates (ECFMG), the international medical school is listed on the World Federation for Medical Education (WFME), the Foundation for Advancement of International Medical Education and Research (FAIMER) World Directory of Medical Schools joint directory, or the World Directory of Medical Schools.

   https://search.wdoms.org/

   -OR-

3. An international medical school that has been approved by the Board.

The medical school must submit all required academic documents (i.e. Certificate of Medical Education Form (Form MED), Certified and Official Transcripts, Certified Copy of Diploma, etc.) through the Board's Direct Online Certification Submission (DOCS) portal, or a recognized third party service.

List each medical school that you have attended.

Press the "Edit" link to edit the record.

Press the "Remove" link to remove the record.

Press "Add" to add a new record.

Press "Previous" to return to the previous section.

Enter appropriate details and press "Next" to continue.

To save and exit this application, click on the "Cancel" button

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Medical School Name	Mailing Address of the Medical School	Attendance Start Date (mm/dd/yyyy)	Attendance End Date (mm/dd/yyyy)	Were You Awarded a Degree?	Title of Degree Awarded	Issue Date of Degree (mm/dd/yyyy)

Add | Previous | Next | Cancel

* Medical School Name:

* Mailing Address of the Medical School:

* Attendance Start Date: (mm/dd/yyyy)

* Attendance End Date: (mm/dd/yyyy)

* Were You Awarded a Degree? ○ Yes ○ No

Next | Cancel

Title of Degree Awarded:

Issue Date of Degree:

- MD - Doctor of Medicine
- MBBS - Bachelor of Medicine and Surgery
- Titulo

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- ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs

Physician's and Surgeon's - Initial Application - ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs - Information

Press "Previous" to return to the previous section.

Enter appropriate details and press "Next" to continue.

To save and exit this application, click on the "Cancel" button

* Are you currently enrolled or will you be enrolled in a California ACGME-accredited postgraduate training program? ○ Yes ○ No

Program Start Date: (mm/dd/yyyy)

Previous | Next | Cancel

- Examinations
- Medical Education
- ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs
- **ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs**
- ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs
- Medical License(s)
- ABMS Certification
- Malpractice History Information
- Disciplinary History
- Practice Impairment or Limitations
- Family Physician Training Program Voluntary Fee
- Third Party Authorization

Physician's and Surgeon's - Initial Application - ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs - Information

List every ACGME, RCPSC, CFPC or CODA Accredited program (internship, residency and fellowship) in which you have participated or are currently participating in, regardless of whether the program was completed or if you received partial credit or no credit.

A Certificate of Completion of ACGME/RCPSC/CFPC Postgraduate Training, Form PTA-PTB, is required to verify participation in all ACGME, RCPSC, or CFPC accredited training whether the program was completed or if you received partial credit or no credit.

A Certificate of Completion of CODA Postgraduate Training, Form CODA1-CODA2, is required to verify any postgraduate training accredited by the Commission on Dental Accreditation (CODA), if completed at the time of application.

You must submit a Form PTA-PTB and/or Form CODA1-CODA2 to each postgraduate training program for completion. The current program director or the designated institutional official (DIO) must provide all of the required information and responses on the form and sign and date the form.

A "Yes" response to any of the questions on Form PTA and/or Form CODA1 requires a signed and dated letter of explanation, on facility letterhead, from the current program director or DIO, which must be submitted through DOCS.

The program must submit the completed form and letter of explanation, if applicable, through the Board's DOCS portal or the Board may accept primary source training verification through the Federation Credentials Verification Service (FCVS). The Board will not accept Form PTA-PTB and/or CODA1-CODA2 if submitted by you or by mail.

Press the "Edit" link to edit the record.

Press the "Remove" link to remove the record.

Press "Add" to add a new record.

Press "Previous" to return to the previous section.

Enter appropriate details and press "Next" to continue.

To save and exit this application, click on the "Cancel" button

- Introduction
- Information Privacy Act
- Transaction Suitability Questions
- Application Questions
- Name and Personal/Organization Details
- Contact Details
- General Information
- Previous Application or License
- Examinations
- Medical Education
- ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs
- **ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs**
- ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs
- Medical License(s)
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- Third Party Authorization
- File Attachments
- Application Summary

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

Add Previous Next Cancel

* Program Facility Name:

* City:

* State/Province:

* Specialty:

* Training Start Date: (mm/dd/yyyy)

* Training End Date: (mm/dd/yyyy)

Next Cancel

Physician's and Surgeon's - Initial Application - ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs - Information

A "Yes" response to any of the questions below requires a signed and dated written explanation from you. Use the Explanation for Application Question, Form EXP, to provide your explanation and attach the signed Form EXP on the Attachments page at the end of this application.

When in doubt as to whether you should disclose a postgraduate training issue, it is best to disclose the information on the application.

Press "Previous" to return to the previous section.

Enter appropriate details and press "Next" to continue.

To save and exit this application, click on the "Cancel" button

* Have you ever received partial or no credit for a postgraduate training program? ○ Yes ○ No

* Have you ever been terminated or dismissed from a program? ○ Yes ○ No

* Have you ever been placed on probation for any reason? ○ Yes ○ No

* Have you ever been disciplined or placed under investigation? ○ Yes ○ No

* Have you ever had any limitations or special requirements placed upon you for clinical performance professionalism, medical knowledge, discipline, or for any other reason, which may include, but is not limited to, a corrective action plan, performance improvement plan, remediation plan, individual development plan, and any type of informal or progressive disciplinary or non-disciplinary action? ○ Yes ○ No

* Have you ever had a postgraduate training program contract not be renewed or offered for a following year? ○ Yes ○ No

Previous Next Cancel

Physician's and Surgeon's - Initial Application - Medical License(s) - Information

List below medical license information for all license(s) ever held (including temporary, provisional, and training licenses) regardless of license status or expiration date.

Press the "Edit" link to edit the record.

Press the "Remove" link to remove the record.

Press "Add" to add a new record.

Press "Previous" to return to the previous section.

Enter appropriate details and press "Next" to continue.

To save and exit this application, click on the "Cancel" button

U.S. State, U.S. Territory or Canadian Province	License Number

Add Previous Next Cancel

Physician's and Surgeon's - Initial Application - Medical License(s) - Add

List below medical license information for all license(s) ever held (including temporary, provisional, and training licenses) regardless of license status or expiration date.

Press "Next" to save this record and continue.

Press "Cancel" if you do not want to save your changes.

ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs

Medical License(s)

* U.S. State, U.S. Territory or Canadian Province:

* License Number:

Next Cancel

ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs

Medical License(s)

ABMS Certification

Malpractice History Information

Disciplinary History

Physician's and Surgeon's - Initial Application - ABMS Certification - Information

Press "Previous" to return to the previous section.

Enter appropriate details and press "Next" to continue.

To save and exit this application, click on the "Cancel" button

* Are you currently certified by a Member Board of the American Board of Medical Specialties? ○ Yes ○ No

Previous Next Cancel

ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs

Medical License(s)

ABMS Certification

Malpractice History Information

Disciplinary History

Practice Impairment or Limitations

Family Physician Training Program Voluntary Fee

Physician's and Surgeon's - Initial Application - Malpractice History Information - Information

NOTE: A "Yes" response to the question below requires a signed and dated written explanation from you. Use the Explanation for Application Question, Form EXP to provide your explanation and attach the signed Form EXP to the Attachments page at the end of this application.

Press "Previous" to return to the previous section.

Enter appropriate details and press "Next" to continue.

To save and exit this application, click on the "Cancel" button

* Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement, judgement, or arbitration? ○ Yes ○ No

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Introduction

Information Privacy Act

Transaction Suitability Questions

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Name and Personal/Organization Details

Contact Details

General Information

Previous Application or License

Examinations

Medical Education

ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs

ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs

ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs

Medical License(s)

ABMS Certification

Malpractice History Information

Disciplinary History

Practice Impairment or Limitations

Family Physician Training Program Voluntary Fee

Physician's and Surgeon's - Initial Application - Disciplinary History - Information

These questions refer to discipline by any hospital, Military or Public Health Service, State Board, or other Governmental Agency of any U.S. state or territory, Canadian province, or federal or international jurisdiction.

NOTE: A "Yes" response to any of the questions below requires a signed and dated written explanation from you. Use the Explanation for Application Question, Form EXP, to provide your explanation and attach the signed Form EXP to the Attachments page at the end of this application.

Press "Previous" to return to the previous section.

Enter appropriate details and press "Next" to continue.

To save and exit this application, click on the "Cancel" button

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

* Have you ever been denied a license to practice medicine or is any denial pending against you? ○ Yes ○ No

* 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

* 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

* 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

* 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

* 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

* Have you ever had hospital or staff privileges terminated, denied, suspended, limited, revoked, or not renewed? ○ Yes ○ No

* Have you ever had any healing arts license or certificate disciplined by another U.S. state, U.S. territory, and/or federal or international jurisdiction? ○ Yes ○ No

Previous Next Cancel

- Medical License(s)
- ABMS Certification
- Malpractice History Information
- Disciplinary History
- Practice Impairment or Limitations
- Family Physician Training Program Voluntary Fee
- Third Party Authorization
- File Attachments
- Application Summary

Physician's and Surgeon's - Initial Application - Practice Impairment or Limitations - Information

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.

NOTE: A "Yes" response to any of the questions below requires a signed and dated written explanation from you. Use the Explanation for Application Question, Form EXP, to provide your explanation and attach the signed Form EXP to the Attachments page at the end of this application.

Press "Previous" to return to the previous section.

Enter appropriate details and press "Next" to continue.

To save and exit this application, click on the "Cancel" button

* Are you currently enrolled in, or participating in any drug, alcohol, or substance abuse recovery program or impaired practitioner program? ○ Yes ○ No

* 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

* Do you have any other condition that may in any way impair or limit your ability to practice medicine safely? ○ Yes ○ No

Previous Next Cancel

- Medical License(s)
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- Disciplinary History
- Practice Impairment or Limitations
- Family Physician Training Program Voluntary Fee
- Third Party Authorization
- File Attachments
- Application Summary

Physician's and Surgeon's - Initial Application - Family Physician Training Program Voluntary Fee - Information

The Song-Brown Health Care Workforce Training Act (Song-Brown Program) was established to increase the number of family physicians to provide needed medical services to the people of California. The program encourages universities and primary care health professionals to provide health care in medically underserved areas, and provides financial support to family medicine, internal medicine, OB/GYN, and pediatric residency programs, family nurse practitioner, physician assistant, and registered nurse education programs throughout California. For further information regarding the program, please visit the California Department of Health Care Access and Information (HCAI) website.

You may voluntarily contribute any amount to the Song-Brown Program. The Board transfers all funds collected monthly to HCAI.

Press "Previous" to return to the previous section.

Enter appropriate details and press "Next" to continue

To save and exit this application, click on the "Cancel" button

* Would you like to contribute? ○ Yes ○ No

Previous Next Cancel

- ABMS Certification
- Malpractice History Information
- Disciplinary History
- Practice Impairment or Limitations
- Family Physician Training Program Voluntary Fee
- Third Party Authorization
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Physician's and Surgeon's - Initial Application - Third Party Authorization - Information

To authorize an individual to receive information about the status of your license application from the Medical Board of California (Board) and/or to authorize an individual to submit documentation on your behalf to the Board as part of the license application, please provide the information below. Upon submission of this application, you are authorizing the Board to provide the individual(s) identified below any and all details of your license application. If you wish to later rescind your authorization of this individual, you must notify the Board in writing.

Press the "Edit" link to edit the record.

Press the "Remove" link to remove the record.

Press "Add" to add a new record.

Press "Previous" to return to the previous section.

Enter appropriate details and press "Next" to continue

To save and exit this application, click on the "Cancel" button

Authorization Type	First Name	Last Name	Email Address

Add Previous Next Cancel

THIS DOCUMENT IS FOR REFERNCE ONLY AND CAN NOT BE SUBMITTED IN PLACE OF A PAPER APPLICATION

- ACGME, RCPSC, CFPC, or CODA Accredited Postgraduate Training Programs
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- Family Physician Training Program Voluntary Fee
- Third Party Authorization
- **File Attachments**
- Application Summary

Physician's and Surgeon's - Initial Application - Attachments

Review the Application for a Physician's and Surgeon's License Information & Checklist for a list of all documents required to be submitted with this application.

If you have electronic copies of any of the documentation listed below, you may attach it here.

- Copy of Completed Request for Live Scan Service form, if you completed Live Scan fingerprinting in California.
- Copy of Name Change Documentation, if applicable.
- Timeline of Activities, Form TOA (signed and dated): Provide the Board with a written chronological description of all professional and non-professional activities for the past five years.
- Explanation to Application Question, Form EXP (signed and dated), if applicable.
- Priority Review and Expedite documentation – To expedite review of your application, you must attach the required supporting documents at the time of application if you meet one of the expedite requirements.

Locate a file with the "Browse" button and press "Attach" or "Remove" as required.

Press "Next" when there are no more files to attach.

Press "Previous" to return to the previous screen.

To save and exit this application, click on the "Cancel" button.

File Name: Choose File No file chosen

Notes:

Note: The character limit for the notes field is 200 characters.

Attach Previous Next Cancel

- Contact Details
- General Information
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- File Attachments
- **Application Summary**

Physician's and Surgeon's - Initial Application - Application Summary

Verify the information below. If any of the information is not correct, press "Previous" to return to the appropriate screen to make corrections.

NOTE: Once you press the "Proceed to Payment" button, you will not be able to return to the application to make any edits nor be able to submit additional required attachments to the Board through this system. If you omitted any information or you responded positively to a question, a signed and dated written explanation using Form EXP is required from you.

Press "Previous" to return to the previous section.

Review the data and press "Proceed to Payment" to submit this application.

To save and exit this application, click on the "Cancel" button.

Physician's and Surgeon's - Initial Application Summary

License Type:	**Physician's and Surgeon's**
Application Date:	**01/30/2024** (mm/dd/yyyy)

Previous Proceed to Payment Cancel

Physician's and Surgeon's - Initial Application - Attestation

As an applicant, you are personally responsible for all information disclosed on your application, including any responses that may have been completed on your behalf or information provided to you by others. The Board may deny your application based upon omission, falsification, or misrepresentation of any item or response on the application or any attachment. Any alterations to any application and/or supporting application forms may result in the denial of your application. The Board considers violations of an ethical nature to be a serious breach of professional conduct.

Press "Previous" to return to the previous section.

Enter the appropriate response and press "Next" to continue to the next section.

To save and exit this application, click on the "Cancel" button.

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Physician's and Surgeon's - Initial Application - Attestation

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Press "Previous" to return to the previous section.

Enter the appropriate response and press "Next" to continue to the next section.

To save and exit this application, click on the "Cancel" button.

I attest 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; 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 and/or alcohol 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 to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I understand that 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.

- ○ **Yes**
- ○ **No**

Previous **Proceed to Payment** **Cancel**