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Postgraduate Training License Application - Introduction

Review the Application for a Postgraduate Training License Information & Checklist for a detailed guide of all license application requirements.

A Postgraduate Training License (PTL) must be obtained within 180 days after beginning an Accreditation Committee for Graduate Medical Education (ACGME) accredited postgraduate training program in California. If a PTL is not issued within 180 days of beginning board-approved postgraduate training in California, all clinical activities must cease until the license is issued. Training beyond the 180 days is considered unlicensed practice of medicine and you can be subject to disciplinary action. The PTL will be issued for 36 months.

<u>Physician's and Surgeon's (P&S) License:</u> If you have received 12 (U.S. or Canadian medical school graduates) or 24 (international medical school graduates) months credit of Board-approved postgraduate training outside of California or in Canada, cancel this application and complete the Application for a Physician's and Surgeon's License. For minimum requirements, information, instructions, and forms, please see the <u>Physician's and Surgeon's License application page on the Board's website.</u>

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 <u>Application for a Postgraduate Training License Information & Checklist</u> to complete each page within the 15-minute time limit.

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 <u>Postgraduate Training License application page on</u> the Board's website.

Press "Next" to continue.

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

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Postgraduate Training License 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 PTL. 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 per sections 2064.5 and 2080 of the California Business and Professions Code (BPC), which authorizes the collection of this information.

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.

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.

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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Postgraduate Training License Application - Function Suitability

Question #1

Applicants who 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) are NOT eligible to obtain a PTL. Please cancel this application and refer to the Physician/s and Surgeon/s-License application-page on the Board's website.

Question #2

Applicants enrolled in an approved ACGME-accredited postgraduate training program in California must obtain the PTL within 180 days of beginning the program.

Question #3

Applicants must have received their medical school education from and graduated from a:

 U.S. or Canadian medical school accredited by the Liaison Committee for Medical Education (LCME), the Committee on Accreditation of Canadian Medical Schools. http://lcme.org/directory/accredited-u-s-programs/

-OR-

 The 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-

 An international medical school approved by the Board. http://www.mbc.ca.gov/Applicants/Medical Schools/Schools Recognized.aspx

Question #4

To meet the minimum examination requirement for a PTL, you must have taken and passed the United States Medical Licensing Examination (USMLE) Steps 1 and 2 (CK) or Part I of the Licentiate of the Medical Council of Canada (LMCC) examination per Section 1328, Title 16, of the California Code of Regulations.

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 a minimum of either 12-months credit (for U.S. or Canadian medical school gradua OR 24-months credit (for international medical school graduate) of ACGME, RCPSC, or CFPC- accredited postgraduate training outside of California? | te); O Yes O No | |
| Are you currently enrolled in an approved ACGME-accredited postgraduate training program in California? | O Yes O No | |
| Did you receive all of your medical school education and graduate from a medical school approved the board? | l by Yes | |
| Have you taken and passed the USMLE Steps 1 and 2 (CK) or part 1 of the LMCC examination? | O Yes O No | |
| | Previous Next Cance | 1 |

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Postgraduate Training License Application - Application Questions

Priority Review and Expedited Licensure: Review additional requirements on qualifying for <u>Priority Review and Expedited</u>
<u>Licensure</u>. 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

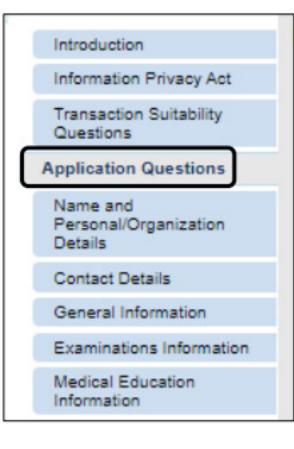
In order to expedite the review of your application, attach a copy of the following documentation on the Attachments page of this application.

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.
- Admitted to the United States as a Refugee, Granted Asylum, or Have a Special Immigrant Visa Status (SIV)
 In order to expedite the 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 "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.



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,
 - 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.

Answer the questions and press "Next" to continue.

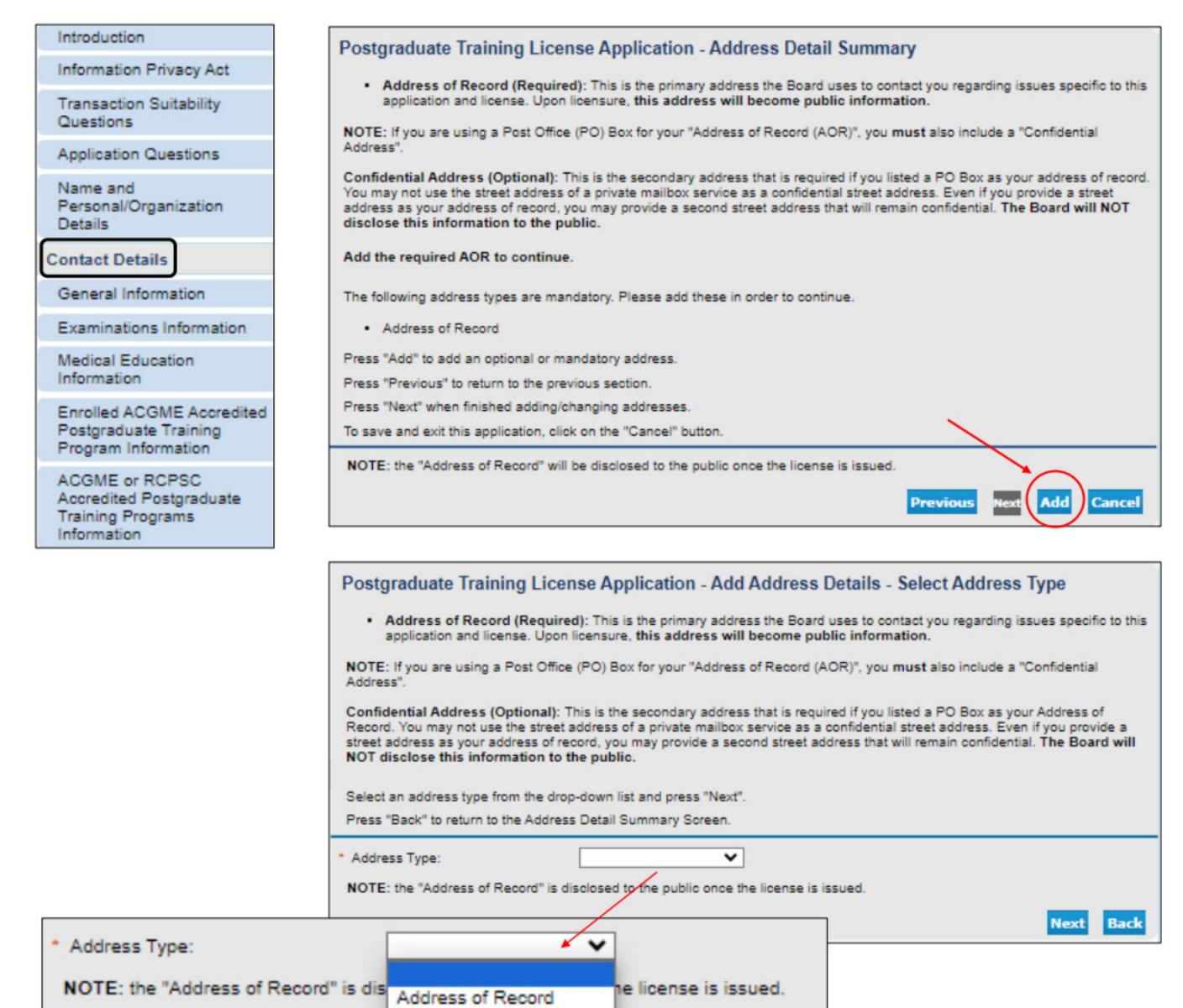
Press "Previous" to return to the previous section.

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

| Have you served or are you currently serving in the United States Armed Forces? | |
|--|-----|
| Are you applying with an Individual Taxpayer Identification Number (ITIN)? | |
| Are you the spouse or domestic partner of an active-duty member of the Armed Forces, holding a current/active license in another state, requesting expediting of this application? | |
| Are you requesting the Board to expedite review of your application as an honorably discharged member of the United States Armed Forces? | |
| Were you admitted to the United States as a Refugee, granted asylum, or have a Special Immigrant Visa status? | |
| Are you requesting a temporary license as a spouse of, or a domestic partner of, 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? | |
| 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? | |
| 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.) | |
| Temporary License for Spouses of Active-Duty Member of the United States Armed Forces: | |
| The Board may issue a temporary Postgraduate Training 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 Californi 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 Arm Forces of the United States who is assigned to a duty station in California under official orders; | ned |
| Evidence of your spouse's or domestic partner's official assignment to a duty station in California; and | |
| Evidence of a current license in another state, district, or territory of the United States. | |
| For minimum requirements, information, instructions, and forms, please visit the <u>Temporary License</u> page on the Board's website | e. |
| SKILLBRIDGE | |
| Pursuant to <u>Business and Professions Code Section 115.4</u> , 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. | |
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| General Information Examinations Information Medical Education Information Enrolled ACGME Accredited Postgraduate Training | Personal/Organization |
| Examinations Information Medical Education Information Enrolled ACGME Accredited Postgraduate Training | Contact Details |
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| Enrolled ACGME Accredited Postgraduate Training | Examinations Information |
| Postgraduate Training | |
| | Postgraduate Training |
| | r rogram information |

| Postgraduate Training L | ense Application - Name and Personal Details | | | |
|---|--|--|--|--|
| You must enter your full legal n | e, including middle name(s) and suffix. | | | |
| 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 ap made under the California Publ | ation and the information contained herein, except for your SSN or ITIN, pursuant to a request ecords Act. | | | |
| Press "Previous" to return to the | evious screen. | | | |
| Enter your personal details and | ess "Next" to continue. | | | |
| To save and exit this application | ick on the "Cancel" button. | | | |
| * First Name: | | | | |
| Middle Name: | | | | |
| * Last Name: | | | | |
| Other Name/Alias: | | | | |
| Suffix: | | | | |
| * U.S. SSN/ITIN: 😡 | | | | |
| * Birth Date: | (mm/dd/yyyy) | | | |
| * Gender: | | | | |
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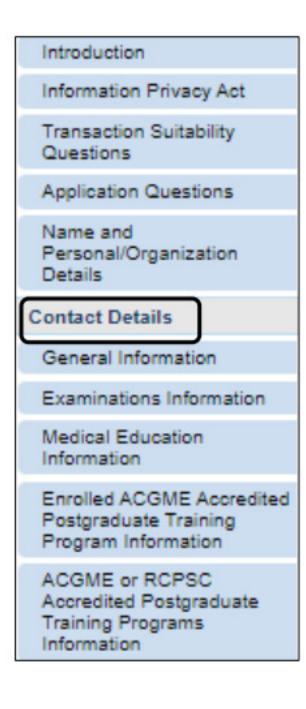


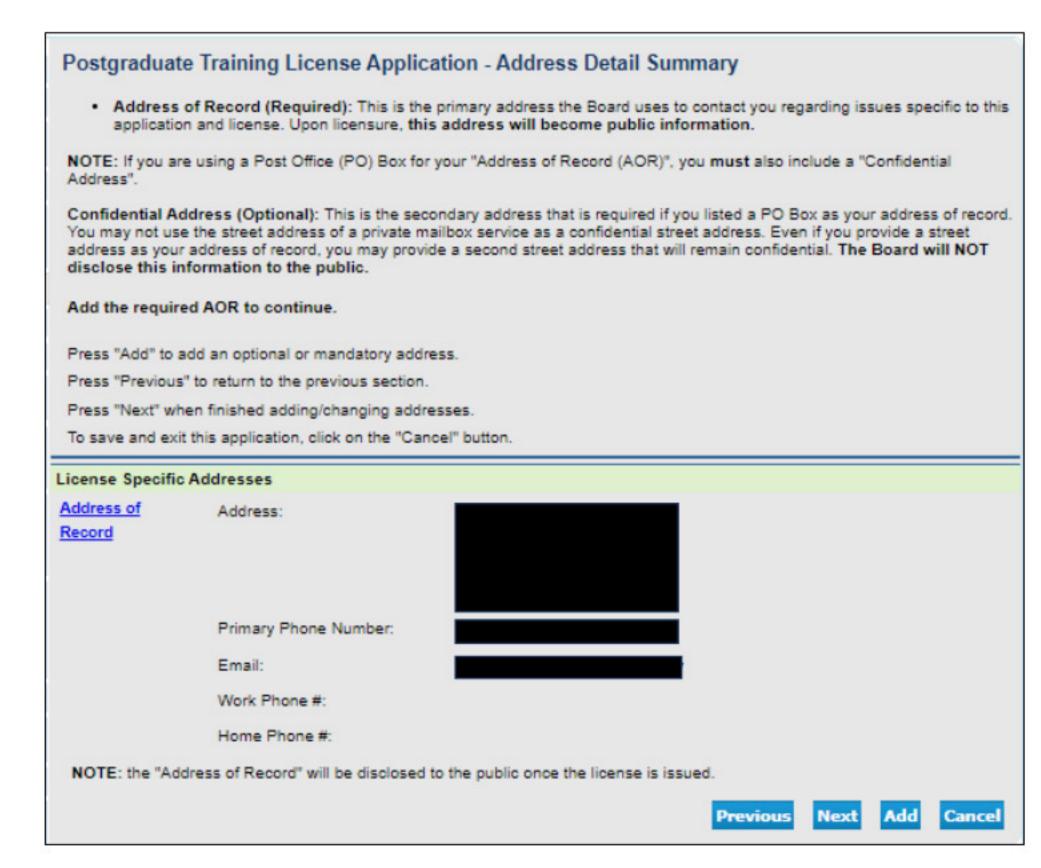
Confidential Address

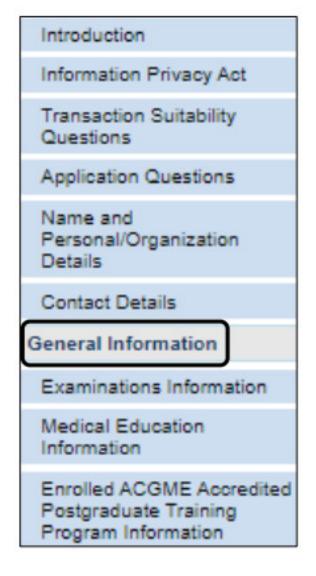
IMPORTANT

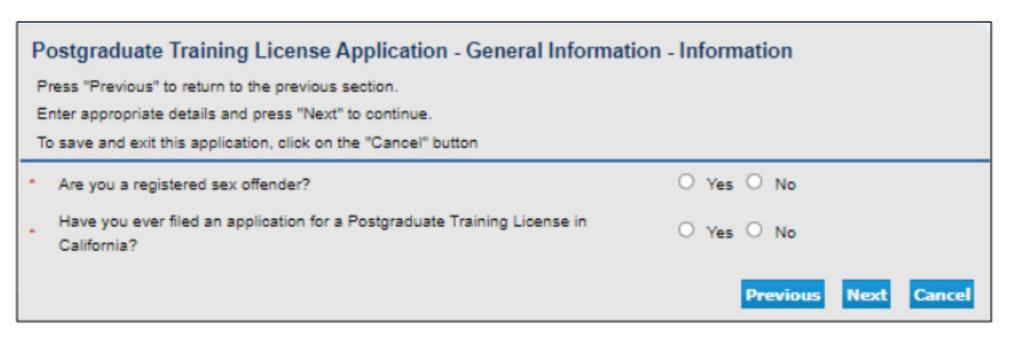
Your email address needs
to be verified before
continuing with the
application. Please go to
your email and click the link
to verify the email address.

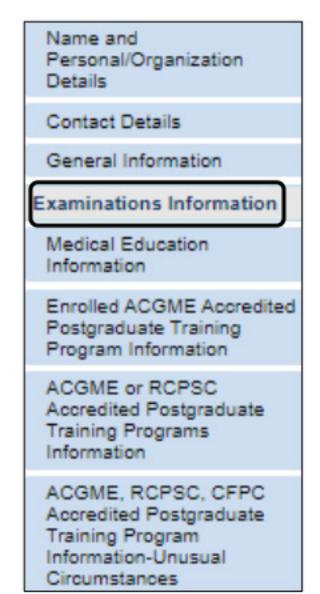
| | License Application - Add Address Details phone number and email address and press "Continue" when done. revious screen. |
|---|---|
| Address of Record | |
| Address Line 1: Address Line 2: Address Line 3: City: State: Zip Code: Country: | California V United States V |
| Primary Phone Number: Extension: Email: Confirm Email: Work Phone #: | |
| | ddress, please select "Out of Country State" from the "State" drop-down menu. Then, enter your required by your country's postal agency. Continue Back |

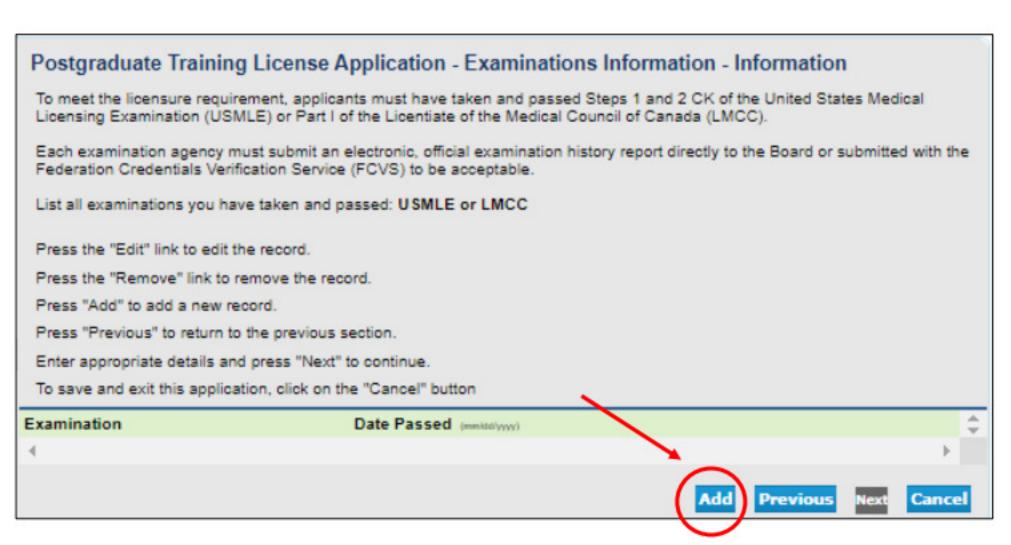


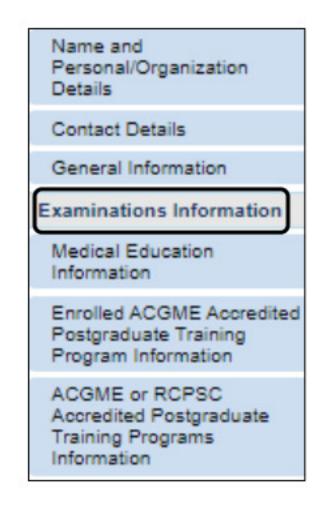


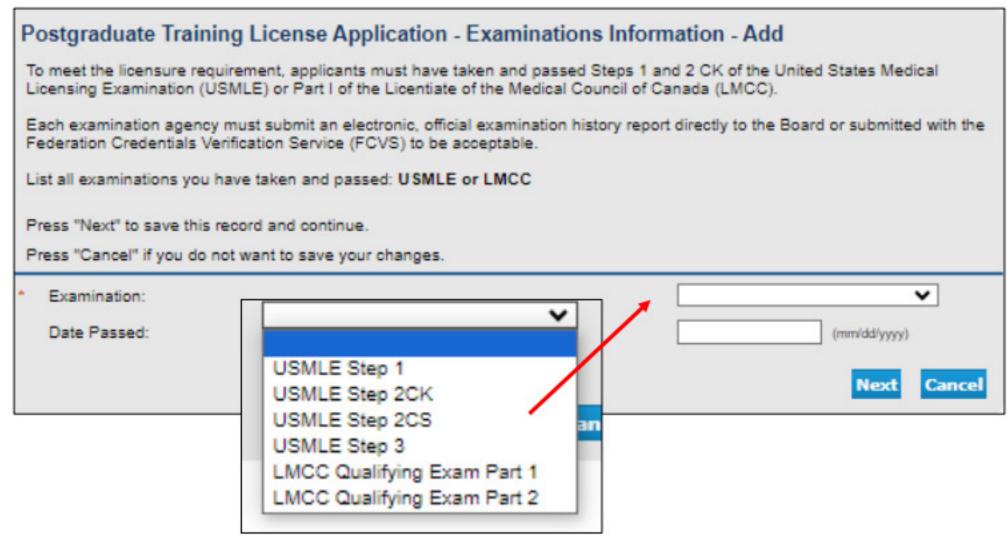




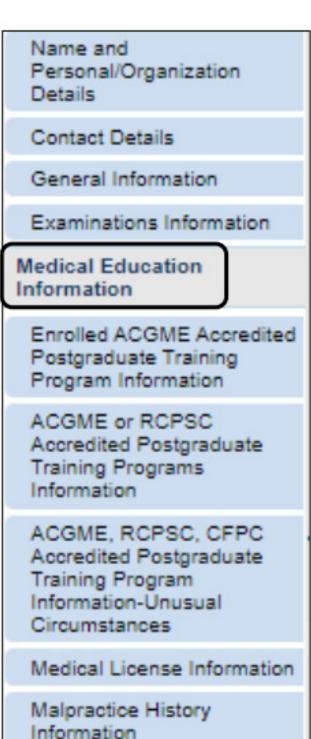


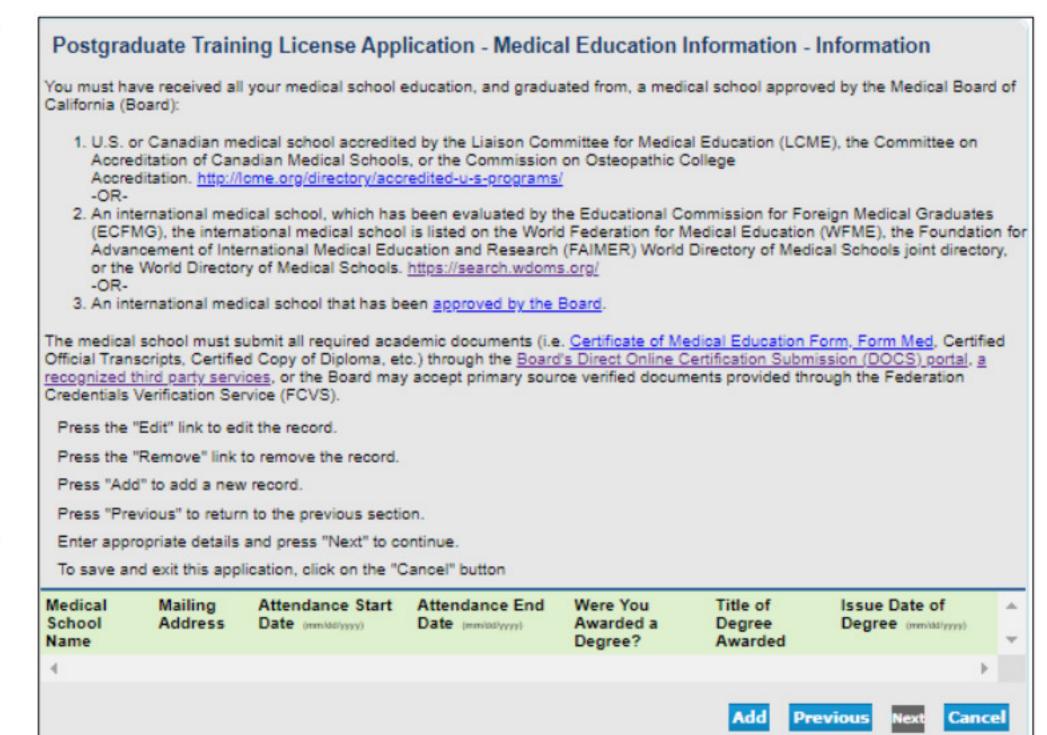












Postgraduate Training License Application - Medical Education Information - Add

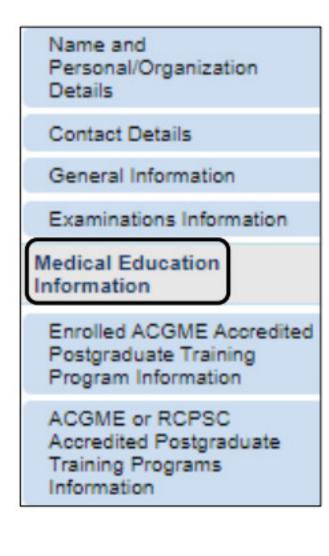
You must have received all your medical school education, and graduated from, a medical school approved by the Medical Board of California (Board):

- 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-
- 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.

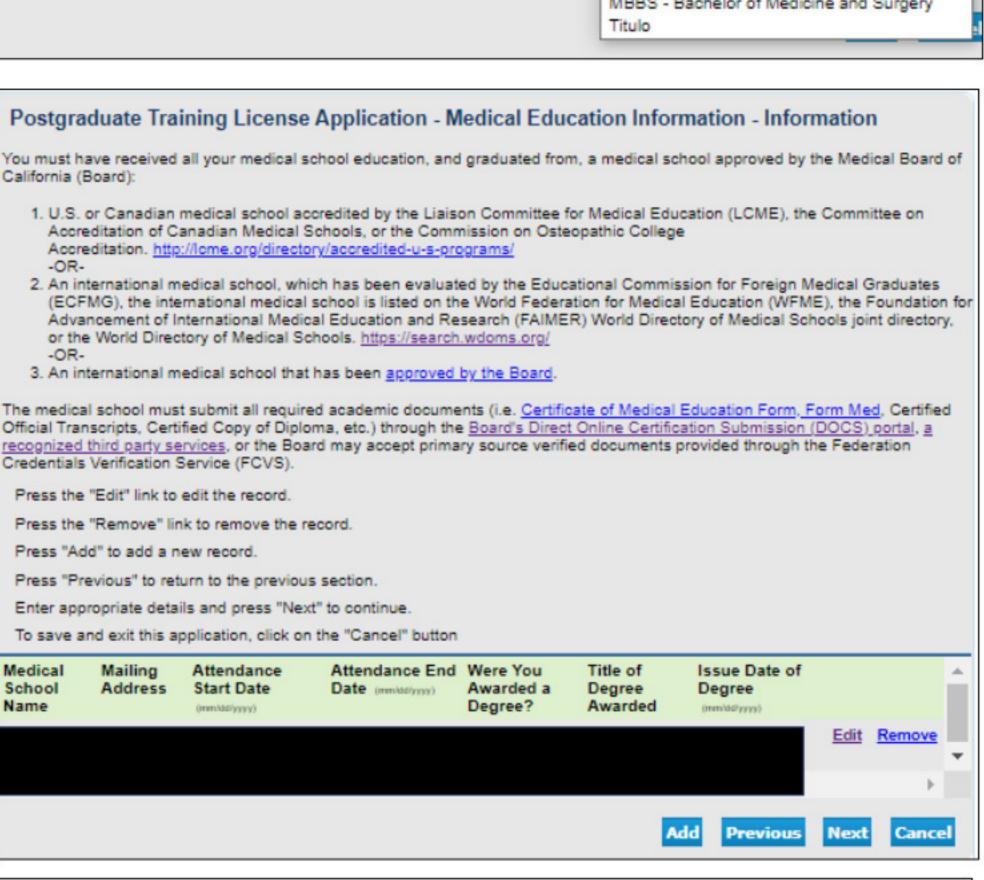
The medical school must submit all required academic documents (i.e. <u>Certificate of Medical Education Form, Form Med</u>, Certified Official Transcripts, Certified Copy of Diploma, etc.) through the <u>Board's Direct Online Certification Submission (DOCS) portal</u>, a <u>recognized third party services</u>, or the Board may accept primary source verified documents provided through the Federation Credentials Verification Service (FCVS).

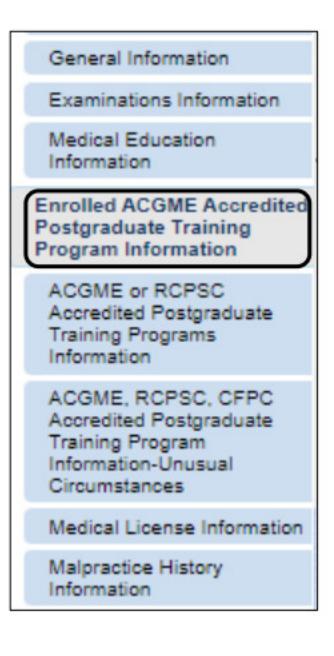
Press "Next" to save this record and continue.

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



| Medical School Name: | |
|--|--|
| * Mailing Address: | |
| Attendance Start Date: | (mm/dd/yyyy) |
| Attendance End Date: | (mm/dd/yyyy) |
| * Were You Awarded a Degree? | ○ Yes ○ No |
| Title of Degree Awarded: Issue Date of Degree: | MD - Doctor of Medicine MBBS - Bachelor of Medicine and Surgery Titulo |

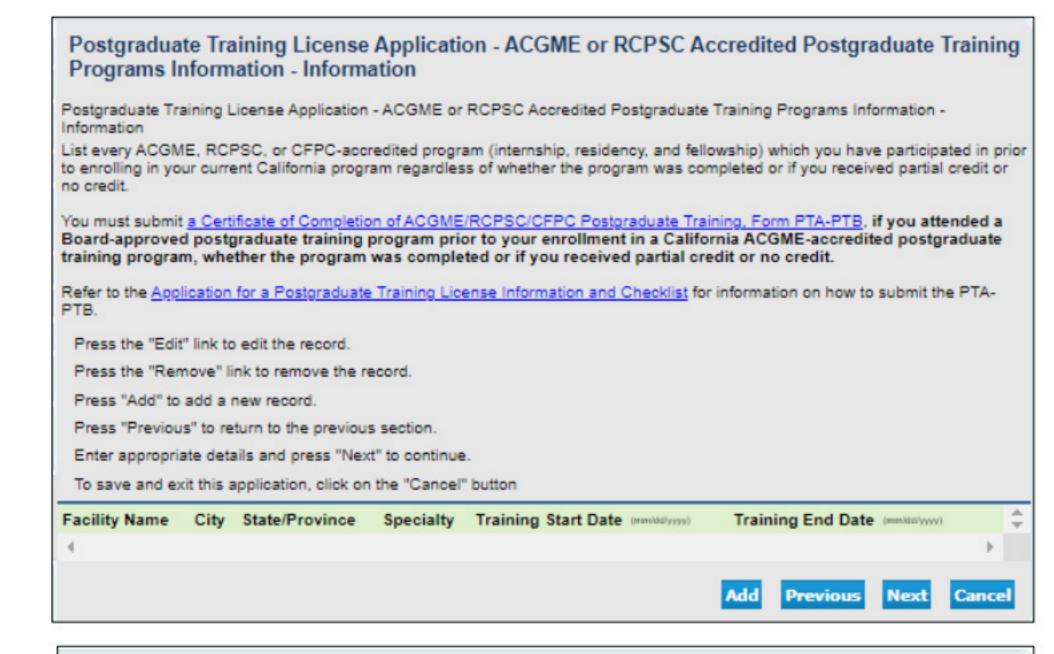




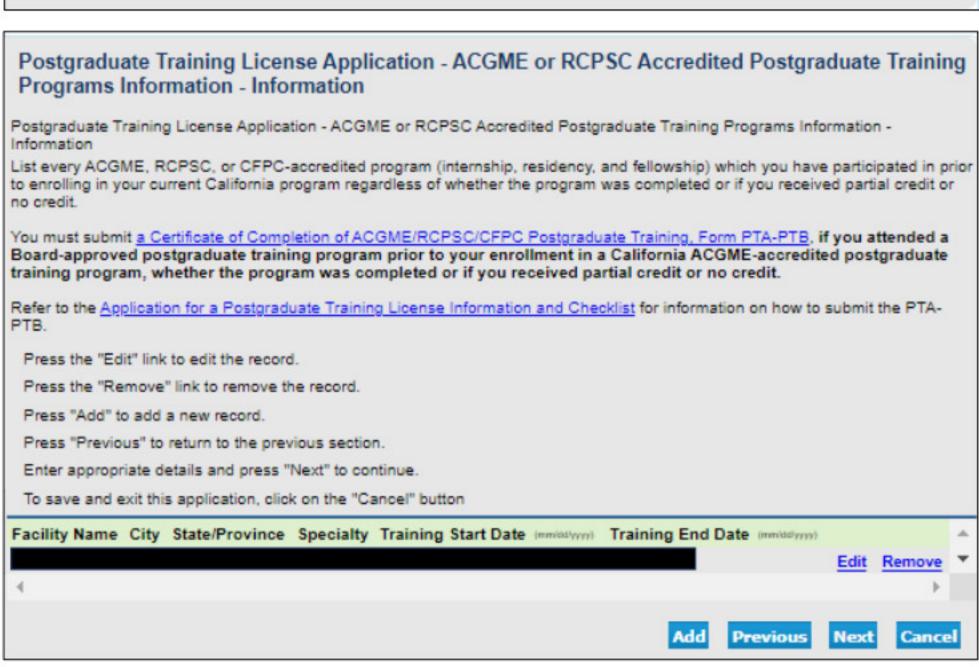
| 1976 | gram Information - Information |
|------|---|
| E | the California ACGME-accredited postgraduate training program where you are enrolled and will be participating in. |
| po | graduate Training License Enrollment Form, Form EF is required to verify your current enrollment in an ACGME-accredited graduate training program in California. Complete the applicant information and submit the form to the current training ram for completion. |
| | current program director or the designated institutional officer (DIO) must provide all required information and responses on orm and sign and date the form. |
| | program must submit the completed Form EF through the Board's DOCS portal if you have an open application wit |
| 4.0 | Board. The Board will not accept the EF if submitted by you or by mail. |
| | Soard. The Board will not accept the EF if submitted by you or by mail. s "Previous" to return to the previous section. |
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Examinations Information Medical Education Information Enrolled ACGME Accredited Postgraduate Training Program Information ACGME or RCPSC Accredited Postgraduate Training Programs Information ACGME, RCPSC, CFPC Accredited Postgraduate Training Program Information-Unusual Circumstances Medical License Information Malpractice History Information Disciplinary History Practice Impairment or

Limitations Information



Postgraduate Training License Application - ACGME or RCPSC Accredited Postgraduate Training Programs Information - Add Postgraduate Training License Application - ACGME or RCPSC Accredited Postgraduate Training Programs Information -List every ACGME, RCPSC, or CFPC-accredited program (internship, residency, and fellowship) which you have participated in prior to enrolling in your current California program regardless of whether the program was completed or if you received partial credit or You must submit a Certificate of Completion of ACGME/RCPSC/CFPC Postgraduate Training, Form PTA-PTB, if you attended a Board-approved postgraduate training program prior to your enrollment in a California ACGME-accredited postgraduate training program, whether the program was completed or if you received partial credit or no credit. Refer to the Application for a Postgraduate Training License Information and Checklist for information on how to submit the PTA-PTB. Press "Next" to save this record and continue. Press "Cancel" if you do not want to save your changes. Facility Name: City: State/Province: ~ Specialty: Training Start Date: (mm/dd/yyyy) (mm/dd/yyyy) Training End Date: Next Cancel



Postgraduate Training License Application - ACGME, RCPSC, CFPC Accredited Postgraduate Medical Education Training Program Information-Unusual Circumstances - Information Information NOTE: A "Yes" response to any of the questions below requires a signed and dated written explanation from you. Use the Enrolled ACGME Accredited Explanation for Application Question, Form EXP, to provide your explanation and attach the signed Form EXP on the attachment Postgraduate Training page at the end of this application. Program Information When in doubt as to whether you should disclose a postgraduate training issue, it is best to disclose the information on the application. ACGME or RCPSC Accredited Postgraduate Press "Previous" to return to the previous section. Training Programs Enter appropriate details and press "Next" to continue. Information To save and exit this application, click on the "Cancel" button ACGME, RCPSC, CFPC O Yes O No Have you ever received partial or no credit for a postgraduate training program? Accredited Postgraduate Training Program O Yes O No Have you ever taken a leave of absence or break from your training? Information-Unusual Circumstances O Yes O No Have you ever been terminated or dismissed from a program? O Yes O No Have you ever been placed on probation for any reason? Medical License Information O Yes O No Have you ever been disciplined or placed under investigation? Malpractice History Information Have you ever had any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any Disciplinary History O Yes O No other reason, which may include, but is not limited to, a corrective action plan. Practice Impairment or performance improvement plan, remediation plan, individual development plan, and Limitations Information any type of informal or progressive disciplinary or non-disciplinary action? Have you ever had a postgraduate training program contract not be renewed or O Yes O No offered for a following year?

ACGME, RCPSC, CFPC
Accredited Postgraduate
Training Program
Information-Unusual
Circumstances

Medical License Information

Malpractice History
Information

Disciplinary History

Practice Impairment or
Limitations Information

Family Physician Training
Program Voluntary Fee

ACGME, RCPSC, CFPC
Accredited Postgraduate
Training Program
Information-Unusual
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Malpractice History
Information

Disciplinary History

Practice Impairment or
Limitations Information

| .S. State/Territory or Canadian Province | License Number |
|--|--|
| To save and exit this application, click on the "Cancel" button | |
| Enter appropriate details and press "Next" to continue. | |
| Press "Previous" to return to the previous section. | |
| Press "Add" to add a new record. | |
| Press the "Remove" link to remove the record. | |
| Press the "Edit" link to edit the record. | |
| List below medical license information for all license(s) ever he of license status or expiration date. | ld, including temporary, provisional, or training license(s) regardles |
| Postgraduate Training License Application - Me | |

Next

Cancel

Previous

Postgraduate Training License 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 attachment 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? Previous Next Cancel

Medical License Information Malpractice History Information Disciplinary History Practice Impairment or Limitations Information Family Physician Training Program Voluntary Fee Third Party Authorization File Attachments Application Summary

Postgraduate Training License 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/territory, Canadian province, or federal or international country.

NOTE: A "Yes" response to any of the questions below requires a signed and dated written explanation from you. Use the <u>Explanation for Application Question, Form EXP</u>, to provide your explanation and attach the signed Form EXP to the attachment 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

| - | Medical License Information Malpractice History Information |
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| Di | isciplinary History |
| | Practice Impairment or Limitations Information |
| | Family Physician Training Program Voluntary Fee |
| | Third Party Authorization |
| - | File Attachments |
| - | Application Summary |

| • | Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason? | 0 | Yes | 0 | No | | | |
|---|---|---|-----|----|--------|------|------|-----|
| • | Have you ever been denied a license to practice medicine or is any denial pending against you? | 0 | Yes | 0 | 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? | 0 | Yes | 0 | 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? | 0 | Yes | 0 | 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? | 0 | Yes | 0 | 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? | 0 | Yes | 0 | 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? | 0 | Yes | 0 | No | | | |
| • | Have you ever had hospital or staff privileges terminated, denied, suspended, limited, revoked, or not renewed? | 0 | Yes | 0 | 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? | 0 | Yes | 0 | No | | | |
| 9 | | | | Pr | evious | Next | Cano | cel |

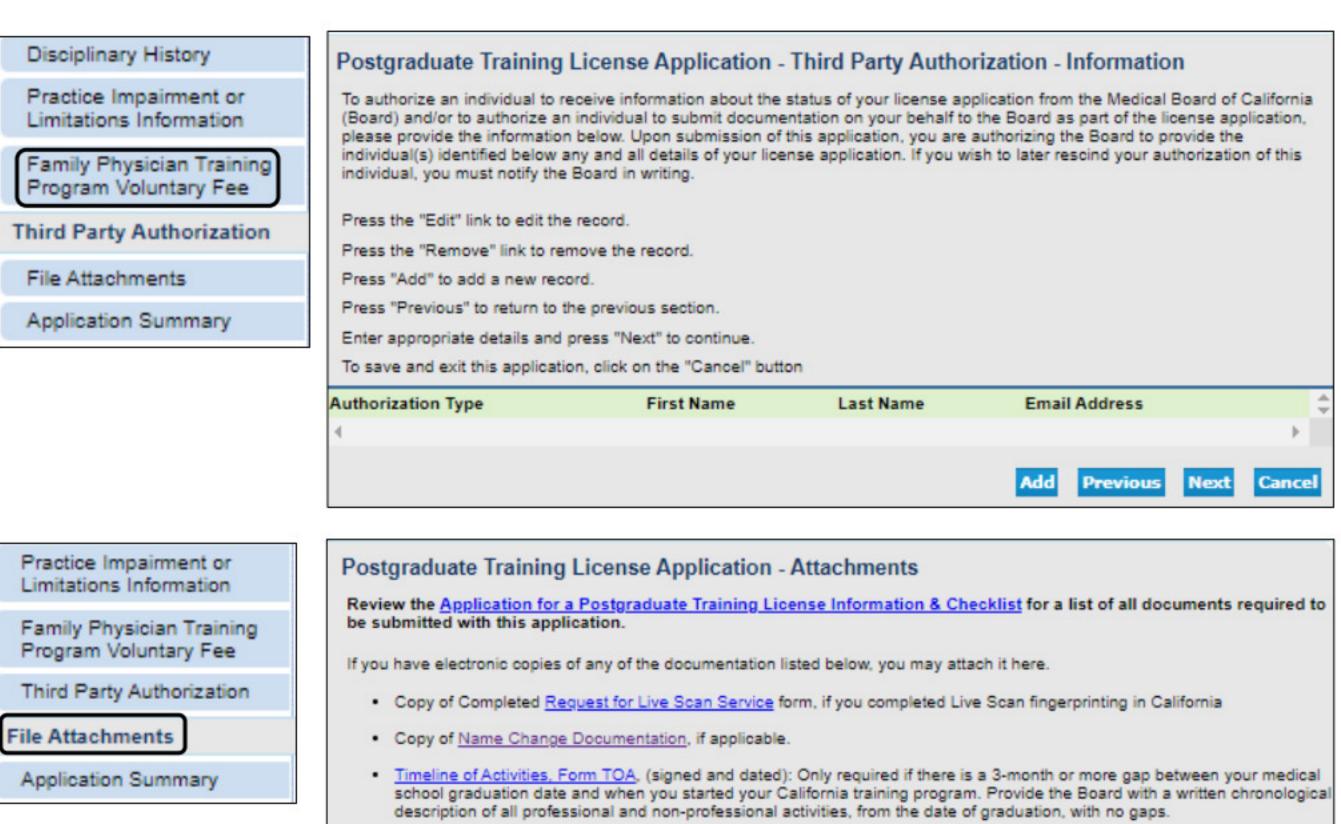
| Malpractice History Information |
|--|
| Disciplinary History |
| Practice Impairment or Limitations Information |
| Family Physician Training Program Voluntary Fee |
| Third Party Authorization |
| File Attachments |
| Application Summary |
| |

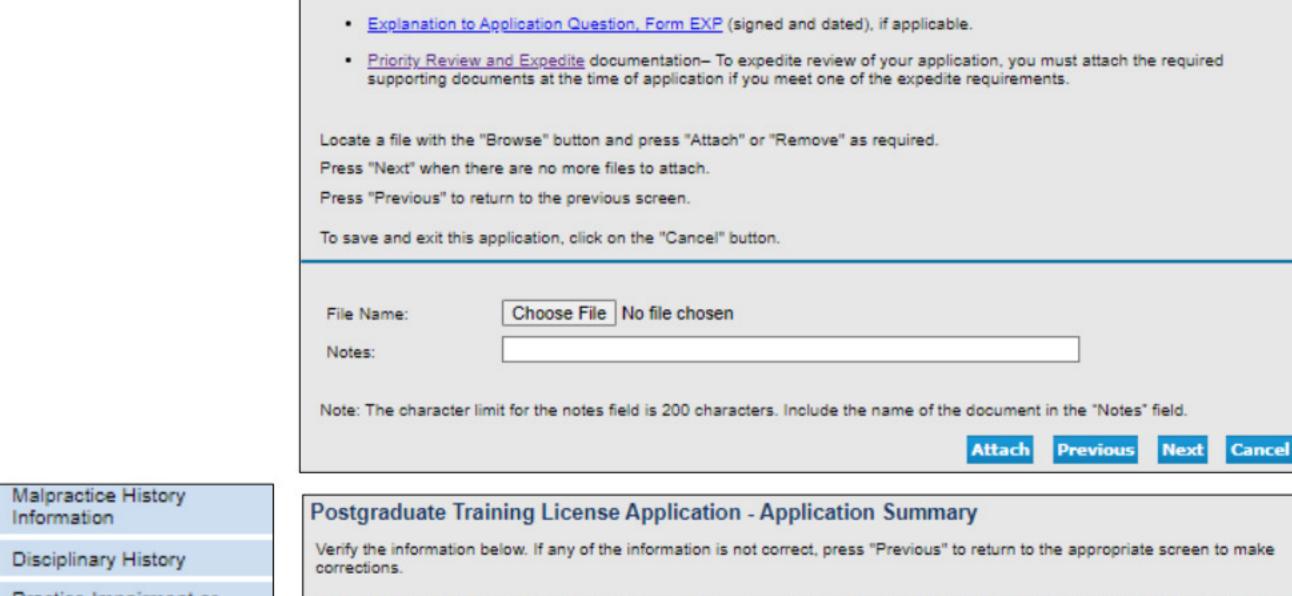
| Postgraduate Training License Application - Practice Impairment or Limitations Information - Information | | | | | | | | | |
|---|---|---|-----|-----|-------|------|--------|--|--|
| | An affirmative answer to any of the questions below will not automatically disqualify you from licensure. The Board 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 <u>Application Information for a Limited Practice License</u> for further information. | | | | | | | | |
| NOTE: A "Yes" response to any of the questions below requires a signed and dated written explanation from you. Use the <u>Explanation for Application Question, Form EXP</u> , to provide your explanation and attach the signed Form EXP to the attachment 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? | 0 | Yes | 0 | 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? | 0 | Yes | 0 | No | | | | |
| | Do you currently have any other condition that impairs or limits your ability to practice medicine safely? | 0 | Yes | 0 | No | | | | |
| | | | | Pre | vious | Next | Cancel | | |

| Practice Impairment or Limitations Information |
|--|
| Family Physician Training Program Voluntary Fee |
| Third Party Authorization |
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Disciplinary History

Postgraduate Training License 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 O Yes O No Would you like to contribute? Previous Next Cancel





Malpractice History
Information

Disciplinary History

Practice Impairment or
Limitations Information

Family Physician Training
Program Voluntary Fee

Third Party Authorization

File Attachments

Application Summary

| File Name: | Choose File No file chosen | | | | | | | | |
|---|---|------------------------------------|--|--|--|--|--|--|--|
| Notes: | | | | | | | | | |
| Note: The characte | r limit for the notes field is 200 characters. Incl | Attach Previous Next Cancel | | | | | | | |
| Postgraduate T | raining License Application - Appli | cation 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. | | | | | | | | |
| | d press "Proceed to Payment" to submit this ap | plication. | | | | | | | |
| To save and exit thi | s application, click on the "Cancel" button. | | | | | | | | |
| Postgraduate Traini | ng License Application Summary | | | | | | | | |
| | License Type: | Postgraduate Training License | | | | | | | |
| | Application Date: | 01/26/2024 (mm/dd/yyyy) | | | | | | | |
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| | | Previous Proceed to Payment Cancel | | | | | | | |
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Malpractice History Information

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Application Summary

Postgraduate Training License 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 Medical Board of California considers violations of an ethical nature to be a serious breach of professional conduct.

Press "Previous" to return to the previous section.

Answer "Yes" or "No" to the Attestation and press "Proceed to Payment" to continue.

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 a | ny | | | | | | |
|--|---|----|--|--|--|--|--|--|
| attachment hereto is a sufficient basis for denying or revoking a license. | | | | | | | | |

O Yes

O No

Previous

Proceed to Payment

Cancel