



CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS



[About BreEZe](#) [FAQ's](#) [Help/Tutorials](#)

[Skip navigation](#)

Logged in as Test, Daisy

[Update Profile](#) | [Logoff](#) | [Contact Us](#)

**Introduction**

Information Privacy Act

Transaction Suitability Questions

Application Questions

Name and Personal/Organization Details

Contact Details

**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.

**Physician's and Surgeon's (P&S) License:** 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 [Physician's and Surgeon's License application page on the Board's website](#).

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 Postgraduate Training License Information & Checklist](#) 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 [Postgraduate Training License application page on the Board's website](#).

Press "Next" to continue.

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

**Next** **Cancel**

Introduction

**Information Privacy Act**

Transaction Suitability Questions

Application Questions

Name and Personal/Organization Details

Contact Details

General Information

Examinations Information

Medical Education Information

Enrolled ACGME Accredited Postgraduate Training Program Information

**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**

|  |
|--|
| Introduction                             |
| Information Privacy Act                  |
| <b>Transaction Suitability Questions</b> |
| Application Questions                    |
| Name and Personal/Organization Details   |
| Contact Details                          |
| General Information                      |
| Examinations Information                 |
| Medical Education Information            |

## 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](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 graduate); OR 24-months credit (for international medical school graduate) of ACGME, RCPSC, or CFPC-accredited postgraduate training outside of California? | <input type="radio"/> Yes<br><input type="radio"/> No |
| Are you currently enrolled in an approved ACGME-accredited postgraduate training program in California?   | <input type="radio"/> Yes<br><input type="radio"/> No |
| Did you receive all of your medical school education and graduate from a medical school approved by the board?  | <input type="radio"/> Yes<br><input type="radio"/> No |
| Have you taken and passed the USMLE Steps 1 and 2 (CK) or part 1 of the LMCC examination?   | <input type="radio"/> Yes<br><input type="radio"/> No |
| <input type="button" value="Previous"/> <input type="button" value="Next"/> <input type="button" value="Cancel"/>   |   |

|  |
|--|
| Introduction                           |
| Information Privacy Act                |
| Transaction Suitability Questions      |
| <b>Application Questions</b>           |
| Name and Personal/Organization Details |
| Contact Details                        |
| General Information                    |
| Examinations Information               |
| Medical Education Information          |

## Postgraduate Training License Application - Application Questions

**Priority Review and Expedited Licensure:** Review additional requirements on qualifying for [Priority Review and 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.
- **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.

- Introduction
- Information Privacy Act
- Transaction Suitability Questions
- Application Questions**
- Name and Personal/Organization Details
- Contact Details
- General Information
- Examinations Information
- Medical Education Information

**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.

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?   | <input type="button" value="v"/> |
| Are you applying with an Individual Taxpayer Identification Number (ITIN)?  | <input type="button" value="v"/> |
| 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?  | <input type="button" value="v"/> |
| Are you requesting the Board to expedite review of your application as an honorably discharged member of the United States Armed Forces?  | <input type="button" value="v"/> |
| Were you admitted to the United States as a Refugee, granted asylum, or have a Special Immigrant Visa status?   | <input type="button" value="v"/> |
| 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?  | <input type="button" value="v"/> |
| 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?  | <input type="button" value="v"/> |
| 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.) | <input type="button" value="v"/> |

**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 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 of a current license in another state, district, or territory of the United States.

For minimum requirements, information, instructions, and forms, please visit the [Temporary License](#) page on the Board's website.

**SKILLBRIDGE**

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.

- Introduction
- Information Privacy Act
- Transaction Suitability Questions
- Application Questions
- Name and Personal/Organization Details**
- Contact Details
- General Information
- Examinations Information
- Medical Education Information
- Enrolled ACGME Accredited Postgraduate Training Program Information

**Postgraduate Training License Application - Name and Personal Details**

You must enter your full legal name, 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 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:     | <input type="text"/>              |
| Middle Name:      | <input type="text"/>              |
| * Last Name:      | <input type="text"/>              |
| Other Name/Alias: | <input type="text"/>              |
| Suffix:           | <input type="text"/>              |
| * U.S. SSN/ITIN:  | <input type="text"/>              |
| * Birth Date:     | <input type="text"/> (mm/dd/yyyy) |
| * Gender:         | <input type="button" value="v"/>  |

- Introduction
- Information Privacy Act
- Transaction Suitability Questions
- Application Questions
- Name and Personal/Organization Details
- Contact Details**
- General Information
- Examinations Information
- Medical Education Information
- Enrolled ACGME Accredited Postgraduate Training Program Information
- ACGME or RCPSC Accredited Postgraduate Training Programs Information

### Postgraduate Training License Application - Address Detail Summary

- Address of Record (Required):** This is the primary address the Board uses to contact you regarding issues specific to this application and license. 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 the 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.**

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.

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**NOTE:** the "Address of Record" will be disclosed to the public once the license is issued.

### Postgraduate Training License Application - Add Address Details - Select Address Type

- Address of Record (Required):** This is the primary address the Board uses to contact you regarding issues specific to this application and license. 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 the 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.**

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" is disclosed to the public once the license is issued.

\* Address Type:

**NOTE:** the "Address of Record" is disclosed to the public once the license is issued.

Address of Record

Confidential Address

### Postgraduate Training License Application - Add Address Details

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:

\* Zip Code:

\* Country:

\* Primary Phone Number:

Extension:

\* Email:

\* Confirm Email:

Work Phone #:

Home Phone #:

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

# 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.**

- Introduction
- Information Privacy Act
- Transaction Suitability Questions
- Application Questions
- Name and Personal/Organization Details
- Contact Details**
- General Information
- Examinations Information
- Medical Education Information
- Enrolled ACGME Accredited Postgraduate Training Program Information
- ACGME or RCPSC Accredited Postgraduate Training Programs Information

### Postgraduate Training License Application - Address Detail Summary

- Address of Record (Required):** This is the primary address the Board uses to contact you regarding issues specific to this application and license. 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 the 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.

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**License Specific Addresses**

|                                   |                       |  |
|-----------------------------------|-----------------------|--|
| <a href="#">Address of Record</a> | Address:              | <div style="background-color: black; width: 150px; height: 40px;"></div> |
|                                   | Primary Phone Number: | <div style="background-color: black; width: 150px; height: 20px;"></div> |
|                                   | Email:                | <div style="background-color: black; width: 150px; height: 20px;"></div> |
|                                   | Work Phone #:         |  |
|                                   | Home Phone #:         |  |

**NOTE:** the "Address of Record" will be disclosed to the public once the license is issued.

[Previous](#) [Next](#) [Add](#) [Cancel](#)

- Introduction
- Information Privacy Act
- Transaction Suitability Questions
- Application Questions
- Name and Personal/Organization Details
- Contact Details
- General Information**
- Examinations Information
- Medical Education Information
- Enrolled ACGME Accredited Postgraduate Training Program Information

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

[Previous](#) [Next](#) [Cancel](#)

- Name and Personal/Organization Details
- Contact Details
- General Information
- 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

### Postgraduate Training License Application - Examinations Information - Information

To meet the licensure requirement, applicants must have taken and passed Steps 1 and 2 CK of the United States Medical Licensing Examination (USMLE) or Part I of the Licentiate of the Medical Council of Canada (LMCC).

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 examinations you have taken and passed: **USMLE or LMCC**

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 <small>(mm/dd/yyyy)</small> |
|-------------|---|
|             |   |

[Add](#) [Previous](#) [Next](#) [Cancel](#)

- Name and Personal/Organization Details
- Contact Details
- General Information
- Examinations Information**
- Medical Education Information
- Enrolled ACGME Accredited Postgraduate Training Program Information
- ACGME or RCPSC Accredited Postgraduate Training Programs Information

### Postgraduate Training License Application - Examinations Information - Add

To meet the licensure requirement, applicants must have taken and passed Steps 1 and 2 CK of the United States Medical Licensing Examination (USMLE) or Part I of the Licentiate of the Medical Council of Canada (LMCC).

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 examinations you have taken and passed: **USMLE or LMCC**

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)

**Next** **Cancel**

- USMLE Step 1
- USMLE Step 2CK
- USMLE Step 2CS
- USMLE Step 3
- LMCC Qualifying Exam Part 1
- LMCC Qualifying Exam Part 2

| Examination    | Date Passed (mm/dd/yyyy) |                      |                        |
|----------------|--------------------------|----------------------|------------------------|
| USMLE Step 1   | 01/01/2021               | <a href="#">Edit</a> | <a href="#">Remove</a> |
| USMLE Step 2CK | 01/01/2022               | <a href="#">Edit</a> | <a href="#">Remove</a> |
|                |                          |                      |                        |

**Add** **Previous** **Next** **Cancel**

- Name and Personal/Organization Details
- Contact Details
- General Information
- 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 Information-Unusual Circumstances
- Medical License Information
- Malpractice History Information

### Postgraduate Training License Application - Medical Education Information - 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 Official Transcripts, Certified Copy of Diploma, etc.) through the [Board's Direct Online Certification Submission \(DOCS\) portal](#), a [recognized third party services](#), or the Board may accept primary source verified documents provided through the Federation Credentials Verification Service (FCVS).

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

| Medical School Name | Mailing Address | 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**

### 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):

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 Official Transcripts, Certified Copy of Diploma, etc.) through the [Board's Direct Online Certification Submission \(DOCS\) portal](#), a [recognized third party services](#), 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.

- Name and Personal/Organization Details
- Contact Details
- General Information
- Examinations Information
- Medical Education Information**
- Enrolled ACGME Accredited Postgraduate Training Program Information
- ACGME or RCPSC Accredited Postgraduate Training Programs Information

\* 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

**Postgraduate Training License Application - Medical Education Information - 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 Official Transcripts, Certified Copy of Diploma, etc.) through the [Board's Direct Online Certification Submission \(DOCS\) portal](#), a [recognized third party services](#), or the Board may accept primary source verified documents provided through the Federation Credentials Verification Service (FCVS).

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

| Medical School Name | Mailing Address | 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) |   |
|---------------------|-----------------|------------------------------------|----------------------------------|----------------------------|-------------------------|-----------------------------------|---|
|                     |                 |                                    |                                  |                            |                         |                                   | <a href="#">Edit</a> <a href="#">Remove</a> |

- General Information
- 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

**Postgraduate Training License Application - Enrolled ACGME Accredited Postgraduate Training Program Information - Information**

Enter the California ACGME-accredited postgraduate training program where you are enrolled and will be participating in.  
[Postgraduate Training License Enrollment Form, Form EF](#) is required to verify your current enrollment in an ACGME-accredited postgraduate training program in California. Complete the applicant information and submit the form to the current training program for completion.

The current program director or the designated institutional officer (DIO) must provide all required information and responses on the form and sign and date the form.

**The program must submit the completed Form EF through the Board's DOCS portal if you have an open application with the Board. The Board will not accept the EF if submitted by you or by mail.**

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

\* Facility Name:

\* City:

\* State:

\* Specialty:

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

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

|   |
|---|
| Examinations Information  |
| Medical Education Information   |
| Enrolled ACGME Accredited Postgraduate Training Program Information                           |
| <b>ACGME or RCPSC Accredited Postgraduate Training Programs Information</b>                   |
| 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 - Information

Postgraduate Training License Application - ACGME or RCPSC Accredited Postgraduate Training Programs Information - 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 no credit.

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 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

| Facility Name  | City | State/Province | Specialty | Training Start Date (mm/dd/yyyy) | Training End Date (mm/dd/yyyy) |
|--|------|----------------|-----------|----------------------------------|--------------------------------|
| <input type="button" value="Add"/> <input type="button" value="Previous"/> <input type="button" value="Next"/> <input type="button" value="Cancel"/> |      |                |           |                                  |                                |

### 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 - 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 no credit.

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:  | <input type="text"/>              |
| * City:   | <input type="text"/>              |
| * State/Province:   | <input type="text" value="v"/>    |
| * Specialty:  | <input type="text"/>              |
| * Training Start Date:  | <input type="text"/> (mm/dd/yyyy) |
| * Training End Date:  | <input type="text"/> (mm/dd/yyyy) |
| <input type="button" value="Next"/> <input type="button" value="Cancel"/> |                                   |

### Postgraduate Training License Application - ACGME or RCPSC Accredited Postgraduate Training Programs Information - Information

Postgraduate Training License Application - ACGME or RCPSC Accredited Postgraduate Training Programs Information - 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 no credit.

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 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

| Facility Name  | City | State/Province | Specialty | Training Start Date (mm/dd/yyyy) | Training End Date (mm/dd/yyyy) |
|--|------|----------------|-----------|----------------------------------|--------------------------------|
| <input type="button" value="Add"/> <input type="button" value="Previous"/> <input type="button" value="Next"/> <input type="button" value="Cancel"/> |      |                |           |                                  |                                |

- 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

- 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 Circumstances
- Medical License Information
- Malpractice History Information**
- Disciplinary History
- Practice Impairment or Limitations Information

- 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 - ACGME, RCPSC, CFPC Accredited Postgraduate Training Program Information-Unusual Circumstances - 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 on the attachment 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 taken a leave of absence or break from your training?  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**

### Postgraduate Training License Application - Medical License Information - Information

List below medical license information for all license(s) ever held, including temporary, provisional, or training license(s) 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/Territory or Canadian Province | License Number |
|---|----------------|
|   |                |

**Add Previous Next Cancel**

### 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?  Yes  No

**Previous Next Cancel**

### 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 [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

|   |
|---|
| Medical License Information                     |
| Malpractice History Information                 |
| <b>Disciplinary History</b>                     |
| 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?  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**

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

### Postgraduate Training License Application - Practice Impairment or Limitations Information - Information

**Important:** The Board recognizes that healthcare providers encounter health conditions, including those involving physical, mental, and substance use disorders, just as their patients and clients do. In addition to providing care for others, the Board encourages and expects its licensees to also seek care for their own health needs and recognizes that doing so is critical to consumer safety and helps sustain California's healthcare workforce.

An affirmative answer to the question 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 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

- Are you currently suffering from any condition that impairs your judgement or otherwise adversely affects your ability to practice medicine safely, that is, in a competent, ethical, and professional manner? You may answer "No" if you have any condition which does not impair your ability to practice medicine safely or if you are receiving appropriate treatment for a condition, and due to that treatment, the condition does not impair your ability to practice medicine safely.  Yes  No

**Previous** **Next** **Cancel**

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

### 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

- Would you like to contribute?  Yes  No

**Previous** **Next** **Cancel**

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

### Postgraduate Training License 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 |
|--|------------|-----------|---------------|
| <input type="button" value="Add"/> <input type="button" value="Previous"/> <input type="button" value="Next"/> <input type="button" value="Cancel"/> |            |           |               |

|   |
|---|
| Practice Impairment or Limitations Information  |
| Family Physician Training Program Voluntary Fee |
| Third Party Authorization                       |
| <b>File Attachments</b>                         |
| Application Summary                             |

### Postgraduate Training License Application - Attachments

Review the [Application for a Postgraduate Training 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): Only required if there is a 3-month or more gap between your medical school graduation date and when you started your California training program. Provide the Board with a written chronological description of all professional and non-professional activities, from the date of graduation, with no gaps.
- [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:  No file chosen

Notes:

Note: The character limit for the notes field is 200 characters. Include the name of the document in the "Notes" field.

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

### Postgraduate Training License 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.

| Postgraduate Training License Application Summary |                               |
|---|-------------------------------|
| License Type:                                     | Postgraduate Training License |
| Application Date:                                 | 01/26/2024 (mm/dd/yyyy)       |

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

- Yes
- No

[Previous](#) [Proceed to Payment](#) [Cancel](#)

### Fee and Summary Report

Your application is not considered submitted and will not be processed until the fees have been paid. Click "Pay Now" to pay your fees.

Review the [Application for a Postgraduate Training License Information & Checklist](#) for a list of all documents required to be submitted with this application.

Additional items may be necessary based upon information provided in the application or information obtained from other entities.

**Third Party Services:** Visit the [Third Party Services](#) webpage for a list of commercial services that may assist you in completing the application for licensure.

**Federation Credentials Verification Service (FCVS):** In addition to this application, you may request FCVS to submit a Medical Professional Information Profile directly to the Board. The Board will review the information provided, along with the application and determine the items that will be accepted from FCVS on an individual basis.

**Grounds for Denial:** The Board reviews each applicant's credentials for licensure in California on an individual basis. The Board has the authority to deny licensure based upon an applicant's act of dishonesty, unprofessional conduct, conviction of a crime, discipline of a license issued by another state or jurisdiction, or inability to practice medicine safely.

**Fees Due:** You must pay all required fees for the Board to review your online application. The Board will determine the application received date based on the receipt of both the application and fees.

Your application data has been submitted. Click on "View PDF Summary Report" and print this report for your records.

You are required to pay the amount below for your application to be processed.

Press "Pay Now" to proceed to the fee payment page.

Press "Add to Cart" to Add to Shopping Cart and return to the main menu.

#### Fees

|  |                 |
|--|-----------------|
| Postgraduate Training License Application Fee: | \$625.00        |
| Department of Justice (DOJ) Fee:               | \$32.00         |
| Federal Bureau of Investigation (FBI) Fee:     | \$17.00         |
| <b>Total Amount Due:</b>                       | <b>\$674.00</b> |

[Pay Now](#) [Add to Cart](#) [View PDF Summary Report](#)



### Online Application Payment

Optionally, reduce payment amount where allowed by deselecting the checkboxes below.

Press "Show Fee Details" to show a breakdown of the fee amounts.

Press "Cancel" to cancel the payment.

| Application Number | Description                               | License Number | License Type                  | Applicant Name | Fee  |
|--------------------|---|----------------|-------------------------------|----------------|--|
| 18284              | Postgraduate Training License Application |                | Postgraduate Training License | [REDACTED]     | \$674.00 <input checked="" type="checkbox"/> |

- Payment Method
- Visa
  - MasterCard
  - Discover
  - American Express

[Next](#) [Show Fee Details](#) [Cancel](#)

**Confirm Payment Details**


PLEASE NOTE: When entering your credit card number on the following screen, please DO NOT include spaces, dashes, or hypens. This action will cause an error, and you will then need to log back into the Online Application Payment portion of the application process.  
Please review the information below and make sure everything is correct. Then, press "Next" to pay for the selected application(s).  
Press "Cancel" if you do not wish to continue with the payment.

| Application Number | Description                               | Applicant Name | Fee             |
|--------------------|---|----------------|-----------------|
| 18284              | Postgraduate Training License Application | [REDACTED]     | \$674.00        |
| <b>Total</b>       |   |                | <b>\$674.00</b> |

Payment Method: **Visa**

[Next](#) [Cancel](#)

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS




**Order Section**

Enter the required information in the fields below.


**Amount** **674.00 USD**



Invoice Number \*

[Checkout](#)

 **Secure Payment**

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS



| Order Section  | Billing Address   |
|--|---|
| <p>Amount <span style="float: right;">674.00 USD</span></p> <p>Invoice Number <span style="float: right;">56014709</span></p>  | <p>Company <input type="text"/></p> <p>First Name <input type="text"/> Last Name <input type="text"/></p> <p>Address1 <input type="text"/></p> <p>Address2 <input type="text"/></p> <p>City <input type="text"/> State/Province <input type="text"/> Postal Code <input type="text"/></p> <p>Country <input type="text"/></p> <p>Email Address <input type="text"/></p> <p>Phone <input type="text"/></p> |
| Payment  |   |
| <p style="text-align: center;">PAYMENT CARD</p> <hr/> <p></p> <p>Card Number <input type="text"/></p> <p>Expiration Date(MMYY) <input type="text"/> CVV2 <input type="text"/></p> |   |
| <a href="#">Submit Payment</a>   |   |
| If you need help regarding payment, please get in touch with your Board or Bureau by returning to the Quick Start Menu and clicking on the Contact Us link.  |   |
|  <b>Secure Payment</b>   |   |

**Order Section**

Amount 674.00 USD  
 Invoice Number 56014709

**Billing Address**



**Confirmation**

Your payment has been approved.

Payment Type CREDITCARD  
 Transaction Type SALE  
 Card Type VISA  
 Card Number [REDACTED]  
 Transaction ID [REDACTED]  
 Date / Time [REDACTED]  
 Message [REDACTED]  
 Approve Code [REDACTED]  
 AVS Response [REDACTED]  
 CVV2 Response [REDACTED]

[Complete](#)

If you need help regarding payment, please get in touch with your Board or Bureau by returning to the Quick Start Menu and clicking on the Contact Us link.



[Skip navigation](#)

Logged in as Test, Daisy

[Update Profile](#) | [Logoff](#) | [Contact Us](#)

**Online Application Payment Success**

Press "Next" to return to the main menu.

Amount Paid: \$674.00  
 Authorization Number: 033252  
 Trace Number: 56014709

| Application Number | Description                               | Applicant Name | Fee      |
|--------------------|---|----------------|----------|
| 8014-18284         | Postgraduate Training License Application | [REDACTED]     | \$674.00 |

[Next](#)