MEDICAL BOARD OF CALIFORNIA
Licensing Program

LICENSE INFORMATION FOR U.S. or CANADIAN MEDICAL SCHOOL GRADUATES

Watch Tutorial

MINIMUM REQUIREMENTS TO APPLY FOR A LICENSE

- To be eligible for a Physician's and Surgeon's license, applicants must have received all of their medical school education from and graduated from a medical school recognized or approved by the Medical Board of California. The medical school's name must exactly match the name on the Board's list of recognized medical schools. If you did not attend or graduate from a recognized or approved medical school you may be eligible for licensure pursuant to Section 2135.7 of the Business and Professions Code (effective 1/2013). Prior to submitting an application, please refer to the Board's website to verify your medical school is recognized:
  http://www.mbc.ca.gov/Applicants/Medical_Schools/Schools_Recognized.aspx
- 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 state tax obligation is not paid. Disclosure of your United States Social Security Number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405 (c)(2)(c)) authorize collection of your social security number. An Individual Taxpayer Identification Number (ITIN) is not acceptable. *Reporting a number on your Application that is not your U.S. Social Security Number may be grounds for denial of licensure.*
- To meet the examination requirement, you must have taken and passed all USMLE Steps 1, 2 and 3 or other acceptable examinations per Section 1328 of Title 16 California Code of Regulations. Please refer to our website to obtain a copy of Section 1328 for a listing of all acceptable examinations. Results of 75 or better are required to satisfy the examination requirement.
- To meet the postgraduate training requirement, you must have satisfactorily completed a minimum of one (1) year of ACGME and/or RCPSC accredited postgraduate training (RCPSC training must be completed in Canada) that includes at least four months of postgraduate training in general medicine. The one year of postgraduate training must consist of 12-continuous months of training within the same program.

GENERAL INFORMATION

- As an applicant, you personally are responsible for all information disclosed on your Application, Forms L1A-L1F, including any responses that may have been completed on your behalf by others. An application may be denied based upon omission, falsification or misrepresentation of any item or response on the application or any attachment. The Medical Board of California considers violations of an ethical nature to be a serious breach of professional conduct.

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2487 www.mbc.ca.gov

GENERAL INFORMATION (Continued)

- **Processing Times:** Application materials are processed in the date order in which the application is received in this office. All application forms and supporting materials are stamped with the date and time received in the office. Generally, you should anticipate receiving written correspondence confirming the status of the application for licensure within 60 days of submission of the application.

- **Fingerprints**: Applicants who reside in California must complete the electronic *Live Scan* fingerprint process. You will need to use the *Request for Live Scan Service* form that may be obtained from our website. Please refer to the following website for a listing of Live Scan facilities in California: http://ag.ca.gov/fingerprints/publications/contact.php

  Applicants residing outside California must submit two completed fingerprint cards or have your fingerprints completed at a California Live Scan facility. Fingerprint cards will be mailed to you once the Board receives your application and appropriate processing fees. All personal data must be completed on the fingerprint cards.

  Please be aware that if you have ever suffered a conviction, the record of the conviction will be reported to the Board as a result of your fingerprint inquiry. *Criminal Records Check from both the California Department of Justice and the Federal Bureau of Investigation must be received prior to the issuance of a Physician's and Surgeon's License.*

- **FCVS**: The Federation Credentials Verification Service (FCVS) is operated by the Federation of State Medical Boards of the United States, Inc. The Medical Board of California (Board) offers this link to FCVS as a convenience to our applicants. You may learn more about FCVS at: http://www.fsmb.org/fcvs.html.

  The Board does not mandate that you use the FCVS. FCVS is NOT a requirement for filing a Physician's and Surgeon's Application. You will be required to complete the Board's application and provide all necessary supporting documentation. As part of your application**,** you may request FCVS to submit directly to the Board your *Medical Professional Information Profile.* We will review the information provided along with our application and determine on an individual basis the items that we will accept from FCVS.

- **Convictions**: Note that convictions adjudicated in juvenile courts or convictions two years or older under Health and Safety Code sections 11357(b), (c), (d), (e) or section 11360(b) need not be reported. Convictions expunged or set aside pursuant to section 1203.4 of the California Penal Code or equivalent non-California law MUST be disclosed. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application. The Board receives information regarding convictions that have been expunged.

- **Grounds for Denial**: Each applicant's credentials for medical licensure in California are reviewed 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 another state license, or inability to practice medicine safely.

- **Due Diligence**: Pursuant to Section 1306 of Title 16 California Code of Regulations, an application shall be deemed abandoned if an applicant fails to complete the application process within 365 days from the date of written notification from the Board of the documents needed to complete the application.

APPLICATION INFORMATION

Listed below are the minimum application and supporting materials required for a U.S. or Canadian medical school graduate to obtain a Physician's and Surgeon's license. This list is not all-inclusive as additional items may be necessary based on responses provided on your *Application* or information obtained from other entities. Please refer to the *License Application Checklist for U.S. or Canadian Medical School Graduates* and our website for further detailed information regarding each requirement.

- Application for Physician's and Surgeon's License, Forms L1A-L1F
- Copy of Live Scan Request Form (CA resident) or Two Fingerprint Cards (Outside CA)
- Application fees of $491.00 or copy of online payment receipt
- Current Curriculum Vitae (CV)
- Official examination scores
- Certificate of Medical Education, Form L2
- Official medical school transcript
- Certified copy of medical diploma
- Official license verifications (if applicable)
- Certificate of Completion of ACGME/RCPSC Postgraduate Training, Form L3A-L3B
- Current Postgraduate Training Enrollment, Form L4 (if applicable)
- Explanation to Question #__ (if applicable)
- Birth Month Licensure Request
- License fees – Refer to *Fee Schedule*

Examination Documentation

- Official examination history reports must be requested from the appropriate examination agency. ***Each examination agency must submit an original, official examination history report directly to the Board to be acceptable.***

Medical Education Documentation

- A Certificate of Medical Education, Form L2, is required from each medical school of attendance. The Form L2 will need to be completed, signed and dated by the school official and affixed with the official medical school seal. Any fields or questions left unanswered will require completion of a new form. ***The Form L2 must be mailed directly from the medical school to the Board to be acceptable.***

- An original official medical school transcript, prepared on university letterhead affixed with the signature of the dean or registrar and the medical school seal, documenting all of the basic science and clinical courses completed during the medical curriculum is required. A transcript is required for each medical school of attendance. ***The transcript must be mailed directly from the medical school to the Board to be acceptable.***

- Certified copy of your medical school diploma is required. The certified copy must have the original signature of the dean or registrar of the medical school, be affixed with the official medical school seal and include a statement attesting that the copy is a true and correct copy of the original. ***The certified copy of your diploma must be mailed directly from the medical school to the Board to be acceptable.***

Postgraduate Training Documentation

- A Certificate of Completion of ACGME/RCPSC Postgraduate Training, Form L3A-L3B, is required to verify the completion of each year of accredited training. The form shall not be completed or signed prior to the last day of the training year that will be used to meet the one year of ACGME or RCPSC accredited postgraduate training required for licensure.

  A Form L3A-L3B must be submitted to each postgraduate training program for completion. The current program director must provide all of the required information and responses on the form, sign and date the form, and affix the hospital seal. If a hospital seal is not available, the program director must sign in the presence of a notary and the notary seal must be affixed. A "yes" response to any of the Unusual Circumstances questions on Form L3A requires a signed and dated letter of explanation from the current program director. ***The completed Form L3A-L3B must be mailed directly from the program to the Board to be acceptable. Any letters of explanation must be provided on program letterhead, signed by the program director and mailed directly to the Board.***

  Please be advised, Section 2065 of the Business and Professions Code allows graduates of U.S. or Canadian medical schools to engage in two years of ACGME-approved postgraduate training without a license. In calculating the maximum two years of training, the Board includes all approved training completed in the U.S. and Canada whether or not any credit was granted. At the end of the two-year period, you must be licensed or all clinical activities in California facilities must cease.

- Current Postgraduate Training Enrollment, Form L4, may be needed if you are currently enrolled in a slotted position in an ACGME/RCPSC accredited postgraduate training program. The Form L4 is used to verify your current accredited postgraduate training and to determine eligibility for the reduced initial licensing fee.

  The Form L4 must be submitted to your current postgraduate training program for completion. The current program director must provide all of the required information and responses on the form, sign and date the form, and affix the hospital seal. If a hospital seal is not available, the program director must sign in the presence of a notary and the notary seal must be affixed. ***The completed Form L4 must be mailed directly from the program to the Board to be acceptable.***

License Verification

- Official license verification is required from <u>each</u> state or Canadian province in which you hold or have held a license. Verification of temporary, training, or provisional license(s) are not required. ***The license verification must be sent directly from the licensing authority to the Board to be acceptable.***

Other Items

- Please submit a signed and dated current Curriculum Vitae (CV) with your application.
- Complete the *Birth Month Request* and submit it with your application.
- The *Explanation to Application Question #__ Form* may be used to provide a detailed written explanation for a "yes" response to a question on the application. The form may be obtained from our website. The Board will also accept a signed and dated letter of explanation.

MEDICAL BOARD OF CALIFORNIA
Licensing Program

License Application Checklist for U.S. or Canadian Medical School Graduates
(Do Not Submit - Keep For Your Records)

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Application, Fees and Fingerprints		
☐ **Application Fee**	A minimum of $491.00 is required to submit an application for licensure. Refer to the *Fee Schedule* for details.	Notes/Date Sent:
☐ **Initial License Fee $808.00 *or* Reduced Initial License Fee $416.50**	Refer to the *Fee Schedule* for details.	Notes/Date Sent:
☐ **Application For Physician's and Surgeon's License, Forms L1A- L1F**	Complete all fields, answer all questions and have the application notarized.	Notes/Date Sent:
Fingerprints: ☐ **Live Scan Form (CA Only)** ***or*** **Two (2) Fingerprint Cards**	Applicants who reside in California must complete the electronic *Live Scan* fingerprint process. A copy of the completed *Request for Live Scan Service* form must be submitted with your application. The form may be obtained from the Board's website. Applicants residing outside of California may submit two completed fingerprint cards or visit a California Live Scan facility. *Fingerprint cards will be mailed to you once the Board receives your application and appropriate processing fees.* All personal data must be completed on the fingerprint cards.	Notes/Date Sent:
Examinations		
☐ **Official Examination Scores from the appropriate examination entity: USMLE, FLEX, NBME, LMCC and State Boards**	Official examination history reports may be requested from the following websites: USMLE, FLEX - *www.fsmb.org* NBME - *www.nbme.org* LMCC (Canada) - *www.mcc.ca* *Refer to CCR, Section 1328, for a list of acceptable examinations.*	Notes/Date Requested:
Medical School Documentation		
☐ **Certificate of Medical Education, Form L2**	Complete the applicant information at the top of the form and mail it to your medical school for completion. A completed Form L2 is required for each medical school attended. *The completed form must be mailed directly from the medical school to the Board to be acceptable.*	Notes/Date Requested:
☐ **Official Medical School Transcript**	An official medical school transcript is required from each medical school attended. *The transcript must be mailed directly from the medical school to the Board to be acceptable.*	Notes/Date Requested:

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License Application Checklist for U.S. or Canadian Medical School Graduates

Medical School Documentation (continued)		
☐ **Certified Copy of Medical School Diploma**	A certified copy of your medical school diploma is required. The certified copy must include a statement verifying authenticity, the signature of the dean or registrar and the official medical school seal must be affixed. *The certified copy of the medical school diploma will need to be submitted directly from the medical school to the Board to be acceptable.*	Notes/Date Requested:
Verification of Postgraduate Training		
☐ **Certificate of Completion of ACGME/RCPSC Postgraduate Training, Forms L3A-L3B**	Verification of each year of ACGME or RCPSC accredited postgraduate training is required. Complete the top section and submit the form to the training program for completion. The form must be completed and signed by the current program director and affixed with a hospital or notary seal. *The Form L3A-L3B must be mailed directly from the residency program to the Board to be acceptable.*	Notes/Date Requested:
☐ **Current Postgraduate Training Enrollment, Form L4** *(if applicable)*	If you are enrolled in an accredited training program at the time of application, this form is necessary to be eligible for the reduced initial licensing fee. Complete the top section and submit the form to the training program for completion. The form must be completed and signed by the current program director and affixed with a hospital *or* notary seal. *The Form L4 must be mailed directly from the residency program to the Board to be acceptable.*	Notes/Date Requested:
Verification of Other State Medical License(s)		
☐ **License Verification**	License verification is required from each state or Canadian province in which you hold or have held a license. Verification of temporary, training, or provisional license(s) are not required. *Request the official license verification to be sent directly from the licensing authority to our Board.*	Notes/Date Requested:
Other Items		
☐ **Birth Month Licensure Request**	Complete the Birth Month Licensure Request form and mail it in with your Application.	Notes/Date Sent:
☐ **Curriculum Vitae (CV)**	Please submit a signed and dated current CV with your Application.	Notes/Date Sent:
☐ **Explanation to Application Question #____** *(if applicable)*	This form may be used to provide a detailed written explanation for a "yes" response to a question on the Application. Please use a separate page for each positive response. The form may be obtained from our website.	Notes/Date Sent:

MEDICAL BOARD OF CALIFORNIA
Licensing Program

FEE SCHEDULE

Application for Physician's and Surgeon's License
or
Postgraduate Training Authorization Letter (PTAL)

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Part 1: Application Fee			
The application fee includes a required fingerprint processing fee. Please note, the application will not be reviewed until the required application fee is received.			
Total Non-Refundable Application Fee	**Required** →		**$ 491.00**
Part 2: License Fee			
License fees are required prior to issuance of your medical license. To reduce delays in issuing a license, you may submit the application and license fees together. **Initial License Fee ($808.00) or Reduced Initial License Fee ($416.50)** – If you currently are enrolled in an ACGME/RCPSC accredited training program, you may be eligible for the reduced initial licensing fee. To verify your enrollment, you will need to submit a Certificate of Current Postgraduate Training, Form L4. **NOTE:** PTAL applicants are not required to submit the initial license fees until all licensing requirements have been met.			
Initial License Fee **or** **Reduced Initial License Fee**	**Required Prior to Licensure**	**$808.00** **or** **$416.50**	**$**
Part 3: Voluntary Fee			
You may contribute $25 to provide training for family physicians and other primary care providers who will serve medically underserved rural and inner city Californians, refugees, the frail elderly and people with AIDS. This program was established as a result of legislation authored by the late Dr. William Filante and is supported by the California Medical Association, the California Academy of Family Physicians, and other leading health care organizations. Dr. Filante's bill authorized this State's Office of Statewide Health Planning and Development (OSHPD) to accept contributions from certain foundations, health maintenance organizations, health insurers and entities to augment these primary care training programs, which are located in hospitals throughout California.			
Family Physician Training Fee	**Voluntary**	**$25.00** (minimum)	**$**
Part 4: Total Amount			**$**

Certified Check, Cashier's Check, Money Order, or Personal Check made payable to:
MEDICAL BOARD OF CALIFORNIA

07A-100 Revised 8/2013

MEDICAL BOARD OF CALIFORNIA
Licensing Program

PHYSICIAN'S & SURGEON'S LIVE SCAN INFORMATION

California's Department of Justice (DOJ) provides statewide Live Scan, which is an electronic fingerprinting system with a subsequent automated background check and response. This system significantly expedites the fingerprint clearance process. **APPLICANTS WHO RESIDE IN CALIFORNIA MUST COMPLETE THE ELECTRONIC LIVE SCAN FINGERPRINT PROCESS.** Applicants residing outside of California may choose this option if visiting the state.

• CALIFORNIA DOES NOT HAVE LIVE SCAN LINKS TO ANY OTHER STATES•

The "Request For Live Scan Service" form (below) is required to have your fingerprints processed by Live Scan. This form must be completed in triplicate; therefore, THREE copies will be printed automatically when printing the form. Please ensure that all personal data (name, AKA's, date of birth, sex, height, weight, eye color, hair color, place of birth, social security number, California driver's license number and home address) is provided on *each of the three forms*. The last section of the form requires information from the fingerprint agency; please ensure this information is completed or the forms will be void. **It is the responsibility of the applicant to ensure that the person scanning the fingerprints submits TWO digital prints, one for the DOJ and one for the FBI.**

Applicants can access the Web site, **http://ag.ca.gov/fingerprints/publications/contact.htm** to obtain the names and location of approved fingerprint sites. Information pertaining to the need for appointments, hours of availability, and rolling fees are also available through that Web site. **After completing the Live Scan process, applicants must submit ONE of the THREE pages with the initial application (Forms L1A-L1E) to document the scanning of their fingerprints.** The results of Live Scan fingerprints are generally received within five (5) days.

If you do not reside in California, you have the option of completing the paper fingerprint cards. You may contact the Board's Consumer Information Unit at (916) 263-2382 to request the paper fingerprint cards. The results of paper fingerprint cards are generally received within twelve 12 weeks.

Whether you use Live Scan or paper fingerprint cards, you will be charged an administrative fee by the local agency that scans the prints or provides the inked impressions. This is in addition to the fingerprint processing fee that must be paid to the Medical Board of California with your application. For information about the fingerprint clearance process and time frames, please see:

http://ag.ca.gov/consumers/morefaqs.php

Because applicants from the medical professions must be concerned with sanitary issues, they wash and scrub their hands so much that images of their fingerprints are often difficult to read. When the impressions are of such poor quality that they cannot be searched in DOJ's fingerprint data base, the fingerprints (whether Live Scan or paper card) are rejected and reprints will be necessary. Therefore, please advise the person processing your fingerprints that extra care needs to be given to ensure that clear impressions have been made.

FINGERPRINT CLEARANCES FROM BOTH THE DOJ AND THE FBI MUST BE RECEIVED PRIOR TO THE ISSUANCE OF A PHYSICIAN'S AND SURGEON'S MEDICAL LICENSE IN CALIFORNIA

If you have ever been convicted of a misdemeanor or felony,
the record of conviction will be reported to the Board as a result of your fingerprint inquiry.

Revised 8/2013

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

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ORI: A0383 (Code assigned by DOJ) Type of Application: LICENSE, CERTIFICATION, PERMIT

Job Title or Type of License, Certification or Permit: PHYSICIAN & SURGEON

Agency Address Set Contributing Agency:

MEDICAL BOARD OF CALIFORNIA
Agency authorized to receive criminal history information

05612
Mail Code (five digit code assigned by DOJ)

2005 EVERGREEN STREET, SUITE 1200
Street No. Street or P.O. Box

CINDY ROGALSKI
Contact Name (Mandatory for all school submissions)

SACRAMENTO CA 95815
City State Zip Code

Contact Telephone No.

Name of Applicant: _____
(Please Print) Last First MI

Alias: _____
Last First

Driver's License No.: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Misc. No. **BIL -** 130065
Agency Billing Number

Height: _____ Weight: _____

Misc. No: _____

Eye Color: _____ Hair Color: _____

Home Address: _____
Street or P.O. Box

Place of Birth: _____

_____
City, State and Zip Code

SOC: _____

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service ☒ DOJ ☒ FBI

If resubmission, list Original ATI No. _____

Employer: (Additional response for agencies specified by statute)

_____
Employer Name

_____
Street No Street or P.O. Box

_____
Mail Code (five digit code assigned by DOJ)

_____
City State Zip Code

( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date: _____
Name of Operator

_____ _____ _____
Transmitting Agency ATI No. Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0383 (Code assigned by DOJ) Type of Application: LICENSE, CERTIFICATION, PERMIT

Job Title or Type of License, Certification or Permit: PHYSICIAN & SURGEON

Agency Address Set Contributing Agency:

MEDICAL BOARD OF CALIFORNIA
Agency authorized to receive criminal history information

05612
Mail Code (five digit code assigned by DOJ)

2005 EVERGREEN STREET, SUITE 1200
Street No. Street or P.O. Box

CINDY ROGALSKI
Contact Name (Mandatory for all school submissions)

SACRAMENTO CA 95815
City State Zip Code

Contact Telephone No.

Name of Applicant: _____
(Please Print) Last First MI

Alias: _____
Last First

Driver's License No.: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Misc. No. **BIL -** 130065
Agency Billing Number

Height: _____ Weight: _____

Misc. No: _____

Eye Color: _____ Hair Color: _____

Home Address: _____
Street or P.O. Box

Place of Birth: _____

_____
City, State and Zip Code

SOC: _____

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service ☒ DOJ ☒ FBI

If resubmission, list Original ATI No. _____

Employer: (Additional response for agencies specified by statute)

_____
Employer Name

_____ _____
Street No Street or P.O. Box Mail Code (five digit code assigned by DOJ)

_____ ( )
City State Zip Code Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date: _____
Name of Operator

_____ _____ _____
Transmitting Agency ATI No. Amount Collected/Billed

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0383 (Code assigned by DOJ) Type of Application: LICENSE, CERTIFICATION, PERMIT

Job Title or Type of License, Certification or Permit: PHYSICIAN & SURGEON

Agency Address Set Contributing Agency:

MEDICAL BOARD OF CALIFORNIA
Agency authorized to receive criminal history information

05612
Mail Code (five digit code assigned by DOJ)

2005 EVERGREEN STREET, SUITE 1200
Street No. Street or P.O. Box

CINDY ROGALSKI
Contact Name (Mandatory for all school submissions)

SACRAMENTO CA 95815
City State Zip Code

Contact Telephone No.

Name of Applicant: _____
(Please Print) Last First MI

Alias: _____
Last First

Driver's License No.: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Misc. No. **BIL -** 130065
Agency Billing Number

Height: _____ Weight: _____

Misc. No: _____

Eye Color: _____ Hair Color: _____

Home Address: _____
Street or P.O. Box

Place of Birth: _____

_____
City, State and Zip Code

SOC: _____

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service ☒ DOJ ☒ FBI

If resubmission, list Original ATI No. _____

Employer: (Additional response for agencies specified by statute)

_____
Employer Name

_____ _____
Street No Street or P.O. Box Mail Code (five digit code assigned by DOJ)

_____ ( )
City State Zip Code Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date: _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

MEDICAL BOARD OF CALIFORNIA
Licensing Program

BIRTH MONTH LICENSURE REQUEST

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California licensing regulations specify that a license expires at 12 midnight on the last day of the birth month of the licensee during the second year of a two year term. If you are licensed in your birth month, your initial license will be valid for a full 24-month term. If you are licensed in a month other than your birth month, the term of your *initial license* will be less than 24-months.

Please indicate your preference by checking one of the options listed below:

☐	**I would like to wait until my birth month of _____ to be licensed.**
☐	**I would like to be licensed as soon as my application is processed. I understand and acknowledge my *initial license* will be valid for less than a 24-month term.**

Printed Name of Applicant: _____
(As it appears on Form L1A)

ATS#: _____
(If Known)

Date of Birth: _____
(mm/dd/yyyy)

Signature of Applicant: _____ Date: _____

Please return the form using one of the following methods:

1. Submit the completed form with your initial application.
2. Fax the completed form to the Board at (916) 263-2487.
3. Mail the completed form to the address listed below.

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2487 www.mbc.ca.gov

MEDICAL BOARD OF CALIFORNIA
Licensing Program

EXPLANATION TO APPLICATION QUESTION #_____

This form may be used to provide a detailed written explanation for a "yes" response to a question on the Application. Please use as many forms as necessary to provide a detailed explanation. A separate form is to be used for each question.

Type or Print Legibly **APPLICANT INFORMATION**

NAME: **Last** **First** **Middle**

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation

NARRATIVE EXPLANATION

SIGNATURE: _____ DATE: _____

Applicant's signature and date are required.

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MEDICAL BOARD OF CALIFORNIA
Licensing Program

APPLICATION

(Please Check All That Apply)

☐ **Physician's and Surgeon's License**
☐ **Postgraduate Training Authorization Letter (PTAL)**
☐ **Update Application: ATS #_____**
☐ **Limited Practice License**

(Please Check One)

☐ **U.S. or Canadian Medical School Graduate**
☐ **International Medical School Graduate**

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Type or Print Legibly	PERSONAL INFORMATION			MBC Use Only
1. Legal Name	Last	First	Middle	
2. Other Names/Alias				
3. United States Social Security Number		**4. Gender**		
		☐ Male ☐ Female		
5. Date of Birth (mm/dd/yyyy)		**6. Place of Birth** (City, State/Country)		
7. Public/Mailing Address **If you are using a P.O. Box please include a confidential street address on a separate sheet of paper. The address of record will be posted on the Medical Board's Web site once you have obtained a license.**	Mailing Address *(30 characters maximum per line, including spaces)*			
	Mailing Address continued *(30 characters maximum per line, including spaces)*			
	City	State/Province	Zip/Postal Code / Country	Personal Information
8. Telephone Numbers	Home #	Work #	Cell #	❑
9. E-mail Address				

10. Have you ever filed an application for a Physician's and Surgeon's License or a PTAL in California that has been withdrawn, abandoned, or denied?	☐ Yes ☐ No	❑
11. Have you previously held a Physician's and Surgeon's License in California? If yes, please provide license number: _____ Expired: _____	☐ Yes ☐ No	Prev License ❑
EXAMINATIONS		Exams
12. Have you ever been found to have engaged in irregular behavior during an examination?	☐ Yes ☐ No	❑
13. Have you ever been subject to an investigation by an examination entity?	☐ Yes ☐ No	❑
14. Are you certified by the Educational Commission for Foreign Medical Graduates? If yes, please provide the Certificate Issue Date: _____	☐ Yes ☐ No	❑

15. List all of the following examinations you have taken: **USMLE, FLEX, NBME, LMCC and/or STATE BOARDS**
(Use the *Addendum to Question #15 Form* if additional space is needed)

Examination	Date (mm/yyyy)	Result (Pass/Fail)	
			❑
			❑
			❑
			❑
			❑

Cashiering Use Only	School Code	L1A

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MEDICAL EDUCATION

MBC Use Only

NOTE: To be eligible for a PTAL or License, all schools attended must be on the Board's list of recognized or approved medical schools. If you did not attend or graduate from a recognized or approved medical school you may be eligible for licensure pursuant to Section 2135.7 of the Business and Professions Code (effective 1/2013). To view the Board's list, please refer to our website at: http://www.mbc.ca.gov/Applicants/Medical_Schools/Schools_Recognized.aspx.

16. List each medical school that you have attended.

Medical School Name	Mailing Address	Attendance Dates (mm/dd/yyyy)		L2 ❑ Trans ❑ School Code
		Start		
		End		
		Start		❑ ❑
		End		
		Start		❑ ❑
		End		

17. School of Graduation	Title of Degree Awarded	Issue Date of Degree (mm/dd/yyyy)	Diploma ❑

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

Unusual Circumstances

18. Did you ever take a leave of absence during medical school?	☐ Yes ☐ No	❑
19. Were you ever placed on probation?	☐ Yes ☐ No	❑
20. Were you ever disciplined or placed under investigation?	☐ Yes ☐ No	❑
21. Were any negative reports ever filed by your instructors?	☐ Yes ☐ No	❑
22. Were any limitations or special requirements imposed on you because of questions of academic or disciplinary problems, or for any other reason?	☐ Yes ☐ No	❑

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

Postgraduate Training

23. Have you participated in any ACGME-accredited postgraduate training in the United States or RCPSC-accredited postgraduate training in Canada? ***List every program in which you have participated or are currently participating, regardless of whether the program was completed or any credit was granted.***
(Use the *Addendum to Question #23 Form* if additional space is needed)

(*If NO please skip to question # 33*) ☐ Yes ☐ No ❑

Facility Name	City, State/Province	Specialty	Training Dates (mm/dd/yyyy)		
			Start		❑
			End		
			Start		❑
			End		
			Start		❑
			End		
			Start		❑
			End		

APPLICANT: (Print Name)

DATE OF BIRTH: (mm/dd/yyyy)

L1B

A "yes" response to questions 18-22 requires a signed and dated written explanation.

Watch Tutorial

UNUSUAL CIRCUMSTANCES DURING POSTGRADUATE TRAINING

MBC Use Only

24. Have you ever received partial or no credit for a postgraduate training program?	☐ Yes ☐ No	❑
25. Have you ever taken a leave of absence or break from your training?	☐ Yes ☐ No	❑
26. Have you ever been terminated, dismissed or expelled from a program?	☐ Yes ☐ No	❑
27. Have you ever resigned from a program?	☐ Yes ☐ No	❑
28. Were you ever placed on probation for any reason?	☐ Yes ☐ No	❑
29. Were you ever disciplined or placed under investigation?	☐ Yes ☐ No	❑
30. Were any incident reports ever filed by instructors?	☐ Yes ☐ No	❑
31. Were any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	☐ Yes ☐ No	❑
32. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	☐ Yes ☐ No	❑

MEDICAL LICENSE

License

33. Have you ever held, or do you currently hold a medical license in any U.S. state, U.S. territory or Canadian province? ***List medical license information below. It is not necessary to list temporary, training, or provisional licenses.***
(Use the *Addendum to Question #33 Form* if additional space is needed)

☐ Yes ☐ No ❑

State/Province	License Number	Issue Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	Dates of Practice (mm/yyyy to mm/yyyy)	
					❑
					❑
					❑
					❑
					❑

ABMS CERTIFICATION

ABMS

34. Are you currently certified by a Member Board of the American Board of Medical Specialties? ☐ Yes ☐ No ❑

Member Board	Certificate Number	Expiration Date (mm/yyyy)

35. Has your certification ever been suspended or revoked?	☐ Yes ☐ No	❑
36. Is there any action currently pending against you?	☐ Yes ☐ No	❑

APPLICANT: (Print Name)

DATE OF BIRTH: (mm/dd/yyyy)

L1C

A "yes" response to questions 24-32 and 35-36 requires a signed and dated written explanation.

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DEA CERTIFICATION

MBC Use Only

37. Are you currently registered with the Drug Enforcement Agency (DEA)?	☐ Yes ☐ No	DEA ❑

DEA Number	State of Issue	Expiration Date (mm/yyyy)	
			❑
			❑

38. Have your DEA privileges ever been denied, suspended, restricted, or terminated?	☐ Yes ☐ No	❑
39. Have you ever entered into any arrangement, agreement or plea in lieu of federal prosecution with the DEA to resolve an alleged violation of a federal or state drug statute or regulation?	☐ Yes ☐ No	❑

MALPRACTICE HISTORY

Malpractice History

40. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement?	☐ Yes ☐ No	❑
41. Has a judgment or arbitration ever been awarded in the amount of $30,000 or more?	☐ Yes ☐ No	❑

DISCIPLINARY HISTORY

Disciplinary History

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

42. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?	☐ Yes ☐ No	❑
43. Have you ever been denied a license to practice medicine?	☐ Yes ☐ No	❑
44. Is any denial pending against you?	☐ Yes ☐ No	❑
45. Have you ever had any license to practice medicine subjected to any disciplinary action?	☐ Yes ☐ No	❑
46. Is any disciplinary action pending against any of your licenses to practice medicine?	☐ Yes ☐ No	❑
47. Have you ever surrendered a license to practice medicine?	☐ Yes ☐ No	❑
48. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	☐ Yes ☐ No	❑
49. 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	❑
50. 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	❑
51. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	☐ Yes ☐ No	❑
52. Is any disciplinary action pending against your hospital or staff privileges?	☐ Yes ☐ No	❑
53. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	☐ Yes ☐ No	❑
54. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?	☐ Yes ☐ No	❑

APPLICANT: (Print Name)	DATE OF BIRTH: (mm/dd/yyyy)	L1D

A "yes" response to questions 38-54 requires a signed and dated written explanation.

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CRIMINAL RECORD HISTORY

MBC Use Only

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

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

Criminal History

55. Have you ever been convicted of, or pled guilty or nolo contendere to **ANY** offense in the United States, its territories, or a foreign country? ***This includes every citation, infraction, misdemeanor and/or felony, including traffic violations. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b), (c), (d), (e), or section 11360(b) which are two years or older should NOT be reported. Convictions that were later expunged from the record of the court or set aside pursuant to section 1203.4 of the California Penal Code or equivalent non-California law MUST be disclosed.***	☐ Yes ☐ No	❑
56. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357(b), (c), (d), (e), or section 11360(b) which are two years or older, have you had a charge or conviction that was set aside or later expunged from the record of the court?	☐ Yes ☐ No	❑
57. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?	☐ Yes ☐ No	❑
58. Are you a registered sex offender?	☐ Yes ☐ No	❑

PRACTICE IMPAIRMENT OR LIMITATIONS

If you give an affirmative answer to any of the questions below, 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. Please refer to the *Application Information for a Limited Practice License* for further information.

Limitations

59. Have you ever been enrolled in, required to enter into, or participated in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?	☐ Yes ☐ No	❑
60. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?	☐ Yes ☐ No	❑
61. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice medicine safely?	☐ Yes ☐ No	❑
62. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice medicine safely?	☐ Yes ☐ No	❑
63. Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?	☐ Yes ☐ No	❑
64. Do you suffer from a progressive disorder or a health condition that will likely result in a general decline in health or function that may impair or limit your ability to practice medicine safely?	☐ Yes ☐ No	❑

APPLICANT: (Print Name)	**DATE OF BIRTH:** (mm/dd/yyyy)	**L1E**

A "yes" response to questions 55-64 requires a signed and dated written explanation.

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PHOTOGRAPH

MBC Use Only

Photograph

Affix a 2" X 2" Photo Here

Photo Must Be Recent and Must Be of your Head and Shoulder Areas Only

Altered Photographs are NOT Acceptable

Notice: All items in this application are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensing per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

Photograph ❑

DECLARATION

Applicant Name & DOB ❑

The applicant, _____, _____,
Please print full name (First, Middle, Last) **Date of Birth (mm/dd/yyyy)**
being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

Applicant Signature & Date ❑

SIGNATURE:_____**DATE:**_____

NOTARY SECTION

Applicant Signature ❑

SIGNATURE OF APPLICANT: _____
(**DO NOT SIGN EXCEPT IN THE PRESENCE OF NOTARY** – Please sign full name)

State of _____

County of _____

Applicant Name & Notary Date ❑

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____,

by, _____ proved to me on the basis of satisfactory evidence
(**Print applicant's name**)

to be the person who appeared before me.

Notary Signature & Seal ❑

NOTARY SEAL

_____
SIGNATURE OF NOTARY PUBLIC

L1F

MEDICAL BOARD OF CALIFORNIA

Licensing Program

CERTIFICATE OF MEDICAL EDUCATION

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Check one: ☐ **U.S. or Canadian Medical School Graduate** ☐ **International Medical School Graduate**

Type or Print Legibly — **APPLICANT INFORMATION** — MBC Use Only

NAME: Last First Middle

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE — Medical School Information

Name of Medical School	❑
State/Province/Country	❑
Did the applicant complete an English Language program? ❑ Yes ❑ No	❑

The undersigned further certifies that the records of this institution show that the applicant attended in this institution _____ *years* of resident instruction, completing at least 4,000 hours, of which at least 80 percent actual attendance is required in the subjects set forth hereunder (Business and Professions Code Sections 2089, 2089.5, 2089.7, 2090, 2091.1, 2091.2). **The standard duration of the curriculum at this institution is _____ years.** ❑

Anatomy
Otolaryngology
Obstetrics and Gynecology
Radiology, including Radiation Safety
Tropical Medicine
Physiology
Biochemistry
Pathology, Bacteriology, and Immunology
Ophthalmology
Dermatology
Embryology
Histology
Human Sexuality
Medicine
Surgery, including Orthopedic Surgery
Urology
Psychiatry
Neurology
Alcoholism and Chemical Dependency
Preventative Medicine, including Nutrition
Physical Medicine
Therapeutics
Neuroanatomy
Child Abuse Detection and Treatment
Geriatric Medicine
Pediatrics
Pharmacology
Anesthesia
Spousal Partner Abuse Detection & Treatment*
Family Medicine**
Pain Management and End-of-Life-Care***

* **ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994**
** **ONLY applicable to medical students who graduated from medical school on or after June 30, 1999**
*** **ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000**

Dates of Attendance

Date the applicant enrolled in medical school:	__ __/ __ __/ __ __ __ __ ❑
Date the applicant was issued the diploma of Bachelor/Doctor of Medicine:	__ __/ __ __/ __ __ __ __ ❑
Date the applicant withdrew from medical school (if applicable):	__ __/ __ __/ __ __ __ __ ❑

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL — Unusual Circumstances

Any "Yes" response below requires a signed and dated letter of explanation by school official.

1. Did this applicant ever take a leave of absence from his/her medical education?	❑ Yes ❑ No ❑
2. Was this applicant ever placed on probation?	❑ Yes ❑ No ❑
3. Was this applicant ever disciplined or placed under investigation?	❑ Yes ❑ No ❑
4. Were any negative reports regarding this applicant ever filed by instructors?	❑ Yes ❑ No ❑
5. Were any limitations or special requirements imposed on this applicant because of questions of academic or disciplinary problems, or for any other reason?	❑ Yes ❑ No ❑

MEDICAL SCHOOL OFFICIAL CERTIFICATION

AFFIX MEDICAL SCHOOL SEAL

I certify that I am the President, Dean, or Registrar and hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.

Signature & Seal ❑

PRINTED NAME OF SCHOOL OFFICIAL **TITLE OF SCHOOL OFFICIAL**

SIGNATURE OF SCHOOL OFFICIAL **DATE**

Attention Medical School: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

L2

NOTE: The completed form must be mailed directly from the medical school to the Board to be acceptable.

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2487 www.mbc.ca.gov

MEDICAL BOARD OF CALIFORNIA
Licensing Program

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CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

Check one: ☐ **U.S. or Canadian Medical School Graduate** ☐ **International Medical School Graduate**

Type or Print Legibly

APPLICANT INFORMATION

NAME: Last First Middle

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form prior to the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the applicant referenced above has satisfactorily completed a period of accredited postgraduate training at this facility and that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state. *The completed form must be mailed directly from the program to the Board.*

Facility Name			
Facility Address			
Specialty		**ACGME 10-digit Program #** http://www.acgme.org/adspublic	__ __ __ __ __ __ __ __ __ __
Dates of Training (mm/dd/yyyy)	Start Date: __ __ / __ __ / __ __ __ __	End Date (or anticipated completion date): __ __ / __ __ / __ __ __ __	

UNUSUAL CIRCUMSTANCES

1. Did the applicant receive partial or no credit for any postgraduate training year?	☐ Yes ☐ No
2. Did the applicant ever take a leave of absence or break from his/her training?	☐ Yes ☐ No
3. Was the applicant ever terminated, dismissed or expelled?	☐ Yes ☐ No
4. Did the applicant ever resign?	☐ Yes ☐ No
5. Was the applicant ever placed on probation?	☐ Yes ☐ No
6. Was the applicant ever disciplined or placed under investigation?	☐ Yes ☐ No
7. Were any incident reports regarding this applicant ever filed by instructors?	☐ Yes ☐ No
8. Were any limitations or special requirements placed upon the applicant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	☐ Yes ☐ No
9. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year?	☐ Yes ☐ No

***Program Director*: Please provide a signed and dated letter of explanation for any "yes" response to questions # 1-9. The explanation must be provided on program letterhead and mailed directly to the Board with the Form L3A-L3B.**

MBC Use Only

Personal Data ☐

Training Information ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

L3A

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2487 www.mbc.ca.gov

GENERAL MEDICINE TRAINING REQUIREMENT

MBC Use Only

To qualify for licensure in California, applicants who are graduates of an international medical school must complete **at least four months** of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete **four months** of training in GENERAL MEDICINE prior to licensure. The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant had direct patient care responsibilities for at least four months in any particular specialty or sub-specialty area.

General Medicine

10. Did the applicant named on the L3A form complete a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC?	❑ Yes ❑ No	❑

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

NOTE: **The completed Form L3A-L3B must be mailed directly from the program to the Board to be acceptable.**

The program director signing this form is formally certifying and documenting under penalty of perjury that the applicant received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to satisfactory performance. The program director is attesting to the fact that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

I hereby declare under penalty of perjury under the laws of the State of California that all of the information contained on these forms is true and correct. I further certify that the training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant named on the Form L3A, and the applicant was trained in an ACGME or RCPSC slotted program position.

Program Director's Signature & Date ❑

PRINTED NAME OF PROGRAM DIRECTOR _____ **Email Address**

SIGNATURE OF PROGRAM DIRECTOR **DATE** _____ **Phone Number**
(Signature Stamp Is Not Acceptable)

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

NOTE: **If a hospital seal is not available, the program director shall also sign in the section below in the presence of a notary public.**

Program Director's Signature ❑

SIGNATURE OF PROGRAM DIRECTOR: _____
(Please sign full name in presence of notary)

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____,

by, _____ proved to me on the basis of satisfactory evidence
(Print program director's name)

to be the person who appeared before me.

Notary Signature & Seal ❑

Hospital Seal ❑

HOSPITAL or NOTARY SEAL

_____
SIGNATURE OF NOTARY PUBLIC

L3B

NOTE: The completed form must be mailed directly from the program to the Board to be acceptable.

MEDICAL BOARD OF CALIFORNIA
Licensing Program

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CURRENT POSTGRADUATE TRAINING ENROLLMENT

Check one: ☐ **U.S. or Canadian Medical School Graduate** ☐ **International Medical School Graduate**

Type or Print Legibly

APPLICANT INFORMATION

NAME: Last First Middle

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

Facility Name			
Facility Address			
Specialty Area		**ACGME 10-digit Program #** http://www.acgme.org/adspublic	__ __ __ __ __ __ __ __ __ __
Dates of Training (mm/dd/yyyy)	Start Date: __ __ / __ __ / __ __ __ __	Anticipated Completion Date: __ __ / __ __ / __ __ __ __	

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

NOTE: The completed Form L4 must be mailed directly from the program to the Board to be acceptable.

I hereby declare under penalty of perjury under the laws of the State of California that the information contained on this form is true and correct. I further certify that the training program is accredited by the ACGME or the RCPSC to offer the type and level of training to the above named applicant and that the applicant is actively participating in a slotted position in an accredited ACGME or RCPSC postgraduate training program.

PRINT NAME OF PROGRAM DIRECTOR **Email Address**

SIGNATURE OF PROGRAM DIRECTOR **DATE** **Phone Number**
(Signature Stamp Is Not Acceptable)

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

NOTE: If a hospital seal is not available, the program director shall also sign in the section below in the presence of a notary public.

SIGNATURE OF PROGRAM DIRECTOR: _____
(Please sign full name in presence of notary)

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____,

by, _____ proved to me on the basis of satisfactory evidence
(Print program director's name)

to be the person who appeared before me.

SIGNATURE OF NOTARY PUBLIC

HOSPITAL or NOTARY SEAL

MBC Use Only

Personal Data ❑

Program Verified ❑

Program Director's Signature & Date ❑

Program Director's Signature ❑

Notary Signature & Seal ❑

Hospital Seal ❑

L4

NOTE: The completed form must be mailed directly from the program to the Board to be acceptable.

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