



MEDICAL BOARD OF CALIFORNIA
Discipline Coordination Unit



Request for Public Documents

Requestor Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Check here if you are requesting certified public documents

Public Information Regarding:

Physician's Full Name: _____

Physician's License Number (if known): _____

Please mail completed *form* to:

**Medical Board of California
Attn: Central File Room
P.O. Box 15588
Sacramento, CA 95852**

or

fax (916) 263-2420