

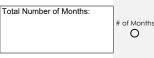
Medical Board of California Initial License Renewal Verification of ACGME/RCPSC/CFPC/CODA Postgraduate Training (LICENSEES ONLY)

The program director must complete and submit Form ILR verifying credit obtained in a board-approved postgraduate training program.

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PROGRAM DIRECTOR TO COMPLETE ACGME, RCPSC,CFPC, or CODA TRAINING INFORMATION

How many months of credit of Board-approved training did the applicant receive at the time this form is signed? (Do not count completed months in a different program and/or the anticipated number of months to be completed.)





APPLICANT INFORMATION				
Full Legal Name				
Full Last Name	First Name	Middle Name	Suffix	Applicant Information O

ATTENTION: PROGRAM DIRECTOR

This form may be signed up to 30 days prior to: completing a year of postgraduate training; or the anticipated last day of postgraduate training if less than one year; or the last day of completion of the program. The program director or the designated institutional official (DIO) must sign this form. If the program director or the DIO is delegating that signature authority to another person, attach evidence of that delegation to this form (may be a photocopy). Such delegation must be on official letterhead and be dated within the last 12 months. The person who signs this form may not be related to the applicant by blood, marriage, or adoption. Wet ink hand signature is required from the program director or DIO. Color copies or electronic signatures will be rejected.

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

The program director or the DIO signing this form is formally certifying and documenting under penalty of perjury that the applicant received instruction appropriate for the postgraduate level and that the applicant satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to satisfactory performance.

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, RCPSC, CFPC, or CODA to offer the type and level of training completed by the applicant named on this form, and the applicant was trained in an ACGME, RCPSC, CFPC, or CODA slotted program position.

P	PRINTED NAME OF PROGRAM DIRECTOR OR DIO			Program Director or DIO's Signature & Date
SIGNATURE OF PROGRAM DIRECTOR OR DIO (Signature stamps are not acceptable) DATE				O
	s not available, the program director or the DIO shal blic if you are submitting the form by mail.	l also sign in the se	ction below in the	
SIGNATURE OF PROGRAM DIRECTOR or DIO:				
	ficer completing this certificate verifies only the identity of the certificate is attached, and not the truthfulness, accuracy, o			his
State of	County of			
Subscribed and sworn	to (or affirmed) before me on this	(PROGRAM	or NOTARY SEAL)	Notary Signature & Seal
day of	, 20,			0
by,				Program Seal O
PRINT	PROGRAM DIRECTOR OR DIO'S NAME			
proved to me based on appeared before me.	a satisfactory evidence to be the person who			
SIGN	IATURE OF NOTARY PUBLIC	L		

This form must be mailed directly to the Medical Board to be acceptable.

Verified

PD or DIO Staff Initials &

Date