**Medical Board of California**

# Program Status Update/Change Form

If the resident holds a Postgraduate Training License or Physician's and Surgeon's License and transfers to another program, is terminated, resigns, takes a leave of absence, or has any other program change affecting the license expiration date or status, a Program Status Update/Change Form is required from the program director or designated institutional official (DIO) within 30 days.

**Licensing Program**
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
www.mbc.ca.gov

MBC USE ONLY

## RESIDENT INFORMATION

**Medical School Graduate: (Check One)** ☐ **U.S. or Canadian** ☐ **International**

Med School O

**Full Legal Name**

| Full Last Name | First Name | Middle Name | Suffix |
|---|---|---|---|
| | | | |

Applicant Information O

**License Number** (Required)

**Date of Birth** (mm/dd/yyyy)

## PROGRAM DIRECTOR TO COMPLETE ACGME TRAINING INFORMATION

Program Name O

**Program Name**

Specialty O

**Specialty** (Required)

**ACGME 10-digit Program#** https://apps.acgme.org/ads/Public (Required)

ACGME O

**Dates of Clinical Training** Start Date (mm/dd/yyyy) | Original Anticipated End Date: (mm/dd/yyyy)

& Date: O

1. Did the resident complete, or will they be completing, research during training that requires them to take a break from training, a leave of absence, change the anticipated clinical training end date, and/or no longer be enrolled in the program? ☐ **Yes** ☐ **No** *If "Yes", please complete the Research Period Questionnaire, Form RES1-RES2.* O

2. Will the resident continue enrollment in the program? ☐ **Yes** *If "Yes" proceed to Section A.* ☐ **No** *If "No" proceed to Section B.* O

## SECTION A – Continued Enrollment in a California Program

**Program Director:** Provide a signed and dated letter of explanation, on program letterhead, including dates, and circumstances for any "yes" response.

**New Anticipated End Date** (mm/dd/yyyy)

& Date: O

3. Did the resident take a leave of absence (LOA) or break from training? ☐ **Yes** ☐ **No** Start Date (mm/dd/yyyy) | End Date (mm/dd/yyyy) O

*If the length of the program extension is shorter than the length of the approved time off, were any leave credits used? If yes, please provide a detailed listing of dates, type of leave used, and the program's current leave policy in the letter of explanation.* O

4. Did the program extend the resident's postgraduate training due to probation or remediation? ☐ **Yes** ☐ **No** Start Date (mm/dd/yyyy) | End Date (mm/dd/yyyy) O

5. Did the resident receive partial or no credit during postgraduate training? ☐ **Yes** ☐ **No** Months of credit granted O

## SECTION B: No Longer Enrolled in a California Program

**Program Director:** For positive responses to questions 6-10, provide a signed and dated letter of explanation including dates, and circumstances. Mail the letter(s) of explanation directly to the Board.

6. Did the resident resign from the program? ☐ **Yes** ☐ **No** Resignation Date (mm/dd/yyyy) O
*In the letter of explanation, include the date of the resident's final day and the reason for the resignation.*

7. Did the program terminate or dismiss the resident? ☐ **Yes** ☐ **No** Effective Date (mm/dd/yyyy) O
*In the letter of explanation, include the date of the resident's final day and the reason for the termination or dismissal from the program.*

8. Did the program decline to renew or offer the resident a postgraduate training program contract for the following year? ☐ **Yes** ☐ **No** O
*In the letter of explanation, include the reason for the decision to not renew or offer the resident a contract for the following year.*

## RESIDENT INFORMATION

**Full Legal Name**

| Full Last Name | First Name | Middle Name | Suffix |
|---|---|---|---|
| | | | |

MBC USE ONLY

Applicant Name ○

## SECTION B: No Longer Enrolled in a California Program *(continued from page 1)*

**9.** Did the resident transfer to another program? ☐ **Yes** ☐ **No**

*If the resident transferred to another California ACGME-accredited training program, the resident must request a Postgraduate Training License Enrollment Form, Form EF, from the new program*

Transfer Date (mm/dd/yyyy) ○

| Reason for Transfer | Program Name and Specialty, if known |
|---|---|
| | |

○

**10.** Is there another reason for the update or change? ☐ **Yes** ☐ **No** ○

## PROGRAM DIRECTOR OFFICIAL CERTIFICATION

The program director or the designated institutional official (DIO) may sign this form. If the program director or the DIO is delegating the 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 must 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.

*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 to offer the type and level of training to the above-named applicant.*

Verified PD Staff Initials & Date

**PRINTED NAME OF PROGRAM DIRECTOR OR DIO**

Program Director's Signature & Date ○

**SIGNATURE OF PROGRAM DIRECTOR OR DIO** **DATE**

**(Original signatures are required. Digital signatures or Signature stamps are not acceptable)**

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

**SIGNATURE OF PROGRAM DIRECTOR OR DIO:**

Program Director's Signature ○

**(SIGN IN PRESENCE OF NOTARY)**

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of _____ County of _____

Subscribed and sworn to (or affirmed) before me on this

_____ day of _____, 20 _____,

by, _____

PRINT PROGRAM DIRECTOR OR DIO'S NAME

proved to me based on satisfactory evidence to be the person who appeared before me.

(PROGRAM or NOTARY SEAL)

Notary Signature & Seal ○

Program Seal ○

_____

**SIGNATURE OF NOTARY PUBLIC**

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