Medical Board of California

Certificate of Completion of ACGME/RCPSC/CFPC Postgraduate Training

Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
Fax: (916) 263-2487
www.mbc.ca.gov

MBC USE ONLY

APPLICANT INFORMATION

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

Applicant Information ○

Legal Name

Full Last Name	First Name	Middle Name	Suffix

Date Of Birth (mm/dd/yyyy)	U.S. SSN or ITIN (Last 4 digits)	Medical School of Graduation

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

Verified Program Information ○

Facility Name

Facility Address

Specialty — Required

ACGME 10-digit Program# https://apps.acgme.org/ads/Public — Required ○

Dates of Training — Start Date (mm/dd/yyyy) — End Date (or anticipated completion date): (mm/dd/yyyy) ○ ○

UNUSUAL CIRCUMSTANCES

Program Director: Provide a signed and dated letter of explanation, including dates, for any "yes" response to questions # 1-7. The explanation must be provided on program letterhead and mailed directly to the Board with this form.

1. Did the applicant receive partial or no credit during postgraduate training? ☐ Yes ☐ No ○

2. Did the applicant ever take a leave of absence or break from training? ☐ Yes ☐ No ○

3. Was the applicant ever terminated, dismissed, or expelled? ☐ Yes ☐ No ○

4. Was the applicant ever placed on probation? ☐ Yes ☐ No ○

5. Was the applicant ever disciplined or placed under investigation? ☐ Yes ☐ No ○

6. Were any limitations or special requirements placed upon the applicant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason? ☐ Yes ☐ No ○

7. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year? ☐ Yes ☐ No ○

GENERAL MEDICINE TRAINING REQUIREMENT

Applicants must complete and receive credit for at **least four (4) months** of general medicine as part of their postgraduate training. 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.

8. Did the applicant complete and received credit for a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC? ☐ Yes ☐ No

Gen Med Required ○

Form **PTA**

APPLICANT INFORMATION

Legal Name

Full Last Name	First Name	Middle Name	Suffix

MBC USE ONLY

Applicant Name ○

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 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.

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. The person who signs this form may not be related to the applicant by blood, marriage, or adoption.

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

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 the applicant 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, RCPSC, or CFPC 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, or CFPC slotted program position.

Verified PD Staff Initials & Date

PRINTED NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR **DATE**

Program Director's Signature & Date ○

Note: If a program 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: _____

(SIGN FULL NAME IN PRESENCE OF NOTARY)

Program Director's Signature ○

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's Name _____

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

(PROGRAM or NOTARY SEAL)

Notary Signature & Seal ○

Program Seal ○

SIGNATURE OF NOTARY PUBLIC

Note: The completed forms must be submitted directly from the program to the Board to be acceptable.

Form PTB