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
www.mbc.ca.gov

MBC USE ONLY

APPLICANT INFORMATION

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

Medical School ○

Full Legal Name

Full Last Name	First Name	Middle Name	Suffix

Applicant Information ○

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

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

Verified Program Information ○

Facility Name Required

Facility Address Required

Specialty Required

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

Specialty/ ACGME # ○

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

Dates of Training ○ ○

How many months of credit of Board-approved training did the applicant receive at the time this form is signed? Total Number of Months:

# of Months ○

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 submitted 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. Has the applicant ever had any limitations or special requirements placed upon them for clinical performance, professionalism, medical knowledge, discipline, or for any other reason, which may include, but is not limited to, a corrective action plan, performance improvement plan, remediation plan, individual development plan, and any type of informal or progressive disciplinary or non-disciplinary action? ☐ Yes ☐ No ○

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

PROCEED TO FORM PTB

Form PTA

APPLICANT INFORMATION

Full Legal Name

Full Last Name	First Name	Middle Name	Suffix

MBC USE ONLY

Applicant Name ○

ATTENTION: PROGRAM DIRECTOR

This form may be signed up to 30 days prior to the last day of any postgraduate training period used to qualify the resident for a Physician's and Surgeon's License. Completion of the training program is not required for the program director to complete the form. The form may be signed either: 30 days prior to the resident obtaining credit for the required months of training; or after each year completed; or once the resident's training concludes at the program. For example, if the resident is enrolled in a 36-month program and 12 months of training are needed to qualify the resident for licensure, then the form may be signed after the resident obtains credit for 11 months of training. Completion of this form will certify that the applicant has satisfactorily completed a period of accredited postgraduate training at this facility.

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 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 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, 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 or DIO Staff Initials & Date

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

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 if you are submitting the form by mail.

SIGNATURE OF PROGRAM DIRECTOR or DIO: _____

(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 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: The program must submit the completed form directly to the Board through the Board's Direct Online Certification Submission (DOCS) portal if the resident has an open application with the Board to be acceptable. If the program is submitting this form for a licensed Physician and Surgeon to fulfill their initial license renewal requirement, then this form must be mailed directly to the Board.

Form **PTB**