Medical Board of California

Research During Training Questionnaire

If program director or the designated institutional official (DIO) indicates that the resident will be completing or has completed a research period as part of their training program, they must complete this form and submit it with Form PTA-PTB, Form EF, or Form PSU1-PSU2.

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

MBC USE ONLY

APPLICANT /RESIDENT INFORMATION

Applicant Information ○

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

Full Legal Name

Full Last Name	First Name	Middle Name	Suffix

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

License Number, if applicable

License #

PROGRAM DIRECTOR TO COMPLETE ACGME TRAINING INFORMATION

Verified Program

Facility Name Required

Specialty/ ACGME # ○

Specialty Required

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

Dates of Training ○ ○

Dates of Clinical Training

Start Date (mm/dd/yyyy)	End Date or Anticipated End Date: (mm/dd/yyyy)

Did the resident complete or will they be completing research as part of their ACGME-accredited postgraduate training program? ☐ Yes ☐ No ○

If "Yes", please answer the following questions:

When is the resident expected to commence and complete the research period?

Start Date (mm/dd/yyyy) ○

End Date: (mm/dd/yyyy) ○

What date is the resident expected to be enrolled in the ACGME-accredited clinical postgraduate training program?

Start Date (mm/dd/yyyy) ○

End Date: (mm/dd/yyyy) ○

Will the resident remain enrolled in the ACGME-accredited training program during the research period? ☐ Yes ☐ No ○

Will the resident receive credit for any ACGME-accredited clinical training completed during the research period? ☐ Yes ☐ No ○

If yes, please provide the number of months of credit that the resident is expected to receive.

Number of Months ○

What is the anticipated date the resident will have obtained 12 months of ACGME-accredited postgraduate training credits for U.S./Canadian medical school graduates or 24 months for international medical school graduates?

Anticipated Date: (mm/dd/yyyy) ○

Form RES1

RESIDENT INFORMATION

Full Legal Name

Full Last Name	First Name	Middle Name	Suffix

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Applicant Name ○

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

The program director or the designated institutional official (DIO) may sign this form. If the program director or the DIO designates 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/DIO Staff Initials & Date

PRINTED NAME OF PROGRAM DIRECTOR OR DIO

Program Director/ DIO's Signature & Date ○

SIGNATURE OF PROGRAM DIRECTOR OR DIO **DATE**

(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/ DIO'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 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 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 or by mail to be acceptable.

Form **RES2**