Medical Board of California

Application for a Postgraduate Training License

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

TYPE OF APPLICATION *(Check One)*

App Type

☐ **U.S. or Canadian Medical School Graduate** ☐ **International Medical School Graduate**

PRIORITY REVIEW AND EXPEDITED LICENSURE

Satisfactory evidence must be provided with your application. See License Information & Checklist for details.

Priority Review

☐ **Honorably Discharged Veterans of the United States Armed Forces**
☐ **Temporary License for Spouse of Active Duty Member of the United States Armed Forces**
☐ **Admitted to the United States as a Refugee, Granted Asylum, or Have a Special Immigrant Visa Status**

PERSONAL INFORMATION

Legal Name

Legal Name

Full Last Name	First Name	Middle Name	Suffix

Other Names/Alias

Date Of Birth

DOB

(mm/dd/yyyy)

SSN/ITITN

☐ **Social Security Number or**
☐ **Individual Taxpayer Identification Number**

Gender

Gender

☐ **Female**
☐ **Male**
☐ **Non-Binary**

Telephone Numbers

(Include area code)

Phone

Primary	Cell	Work

Email Address (Required)

Email

Address Of Record

This address will be used for all current correspondence during the review process and will be posted on the Board's website upon issuance of a license. If you are using a P.O. Box, you are also required to list a confidential street address.

AOR

Line 1 (40 characters per line, including spaces)	Line 2 (40 characters per line, including spaces)		
City	**State/Province**	**Zip/Postal Code**	**Country**

Confidential Address

Only required if Address of Record is a P.O. Box

Conf. Address

Line 1 (40 characters per line, including spaces)	Line 2 (40 characters per line, including spaces)		
City	**State/Province**	**Zip/Postal Code**	**Country**

Sex Offender

1. Are you a registered sex offender? ☐ Yes ☐ No

PTL

2. Have you ever filed an application for a Postgraduate Training License in California? ☐ Yes ☐ No

Military

3. Are you currently serving, or have you previously served, in the military? ☐ Yes ☐ No

EXAMINATIONS

ECFMG

4. Are you certified by the Educational Commission for Foreign Medical Graduates? ☐ Yes ☐ No

List all of the following examinations you have taken and passed: (USMLE or LMCC)

Exams

Examination	**Date Passed** (mm/dd/yyyy)

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Cashiering | Modifier | School Code

Form **PTL1**

Applicant Full Legal Name | **Date of Birth** (mm/dd/yyyy)

MEDICAL EDUCATION

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List each medical school that you have attended and the medical school of graduation.

Name & DOB ○

Medical School		Date of Attendance	Medical Education
Name		Start Date (mm/dd/yyyy)	MED ○ Trans ○
Mailing Address		End Date (mm/dd/yyyy)	School Code
Name		Start Date (mm/dd/yyyy)	MED ○ Trans ○
Mailing Address		End Date (mm/dd/yyyy)	School Code

Medical School of Graduation	Title of Degree Awarded	Issue Date of Degree	
		(mm/dd/yyyy)	Diploma ○

ACGME ACCREDITED POSTGRADUATE TRAINING PROGRAMS

(Internship, Residency and Fellowship Programs)

List the ACGME accredited postgraduate training program where you are enrolled and will be participating in California.

Facility		Specialty	Dates of Training
Facility Name		Specialty	Start Date (mm/dd/yyyy)
City, State/Province			End Date (mm/dd/yyyy)

○

List every ACGME, RCPSC, or CFPC accredited program (internship, residency and fellowship) which you have participated in, regardless of whether the program was completed or any credit was granted.

Facility		Specialty	Dates of Training
Facility Name		Specialty	Start Date (mm/dd/yyyy)
City, State/Province			End Date (mm/dd/yyyy)
Facility Name		Specialty	Start Date (mm/dd/yyyy)
City, State/Province			End Date (mm/dd/yyyy)

○

○

A "yes" response to questions 5 – 11 requires a signed and dated written explanation. Use the Explanation For Application Question (Form EXP) form to provide your explanation. When in doubt as to whether a postgraduate training issue should be disclosed, it is best to disclose the information on the application.

5.	Have you ever received partial or no credit for a postgraduate training program?	☐ Yes ☐ No	○
6.	Have you ever taken a leave of absence or break from your training?	☐ Yes ☐ No	○
7.	Have you ever been terminated, dismissed, or expelled from a program?	☐ Yes ☐ No	○
8.	Have you ever been placed on probation for any reason?	☐ Yes ☐ No	○
9.	Have you ever been disciplined or placed under investigation?	☐ Yes ☐ No	○
10.	Have you ever had any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	☐ Yes ☐ No	○
11.	Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	☐ Yes ☐ No	○

Form **PTL2**

Applicant Full Legal Name _____ **Date of Birth** (mm/dd/yyyy) _____

MEDICAL LICENSE

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List medical license information for all licenses ever held below. Do not list temporary, training, or provisional licenses.

Name/DOB ○

U.S. State, U.S. Territory, or Canadian Province	License Number	Dates of Practice	
		(mm/dd/yyyy) to	(mm/dd/yyyy) ○
		(mm/dd/yyyy) to	(mm/dd/yyyy) ○
		(mm/dd/yyyy) to	(mm/dd/yyyy) ○
		(mm/dd/yyyy) to	(mm/dd/yyyy) ○

DISCIPLINARY HISTORY

These questions refer to discipline by any hospital, military or public health service, licensing board, or other governmental agency of any U.S. state, U.S. territory, Canadian province, or foreign country. If in doubt as to whether discipline should be disclosed, it is best to disclose the information on the application.

A "yes" response to question 12-20 requires a signed and dated written explanation. The Explanation For Application Question (Form EXP) may be used to provide your explanation.

12. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason? ☐ Yes ☐ No ○

13. Have you ever been denied a license to practice medicine or is any denial pending against you? ☐ Yes ☐ No ○

14. Have you ever had any license to practice medicine subjected to any disciplinary action or is any disciplinary action pending against any of your licenses to practice medicine? ☐ Yes ☐ No ○

15. Have you ever surrendered a license to practice medicine or have you ever had any license to practice medicine revoked, suspended, or placed on probation? ☐ Yes ☐ No ○

16. Have you ever had any license to practice medicine subjected to any action including, but not limited to, informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation? ☐ Yes ☐ No ○

17. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital? ☐ Yes ☐ No ○

18. Have you ever resigned from a medical staff position in lieu of disciplinary or administrative action or is any disciplinary action pending against your hospital or staff privileges? ☐ Yes ☐ No ○

19. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed? ☐ Yes ☐ No ○

20. Have you ever had any healing arts license or certificate disciplined by another state or federal territory? ☐ Yes ☐ No ○

Applicant Full Legal Name _____ **Date of Birth** (mm/dd/yyyy) _____

PRACTICE IMPAIRMENT OR LIMITATIONS

Please note that an affirmative answer to any of the questions below will not automatically disqualify you from licensure. The Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are eligible for licensure. Please note that a limited practice license may be available. Refer to the Application Information for a Limited Practice License for further information.

A "yes" response to question 21-23 requires a signed and dated written explanation. The Explanation For Application Question (Form EXP) may be used to provide your explanation.

21. Are you currently enrolled in, or participating in any drug, alcohol, or substance abuse recovery program or impaired practitioner program? ☐ Yes ☐ No ○

22. Do you currently have any condition (including, but not limited to emotional, mental, neurological or other physical, addictive, or behavioral disorder) that impairs your ability to practice medicine safely? ☐ Yes ☐ No ○

23. Do you currently have any other condition that impairs or limits your ability to practice medicine safely? ☐ Yes ☐ No ○

PROCEED TO FORM PTL5

PHOTOGRAPH AND NOTICE

MBC USE ONLY

Affix a 2" by 2" photo here.

Photo must be recent and must be of your head and shoulder areas only.

Altered photos are NOT acceptable.

Notice: All items in this application are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensing per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act.

Reviewed PTL1-5 ○

Staff Initials & Date

Photo ○

DECLARATION

The applicant, Full Legal Name (First, Middle, Last, Suffix) _____ , Date of Birth (mm/dd/yyyy) _____

Applicant Name & DOB ○

being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; and that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug, alcohol and/or substance abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, FALSIFICATION, OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

Applicant Signature & Date ○

SIGN LEGAL NAME: _____ **DATE:** _____

NOTARY SECTION

Applicant Signature ○

SIGNATURE OF APPLICANT: _____

(SIGN LEGAL NAME IN THE 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 Applicant's Legal Name _____

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

(NOTARY SEAL)

Applicant Name & Notary Date ○

Notary Signature & Seal ○

_____

SIGNATURE OF NOTARY PUBLIC

Form **PTL5**