Medical Board of California

Application to Restore License to Full, Active Status from Inactive, Disabled or Fee Exempt Status or from Disabled Status to Active Status with Limitations on Practice

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

LICENSEE INFORMATION

Full Legal Name

Last Name	First Name	Middle Name	Suffix

California License Number

Please log into your BreEZe account to ensure your information is up to date (i.e. Address of record, email address and telephone number) prior to submission of this form. **All correspondence will be sent to the email address listed in your account.**

RESTORATION TYPES

Please provide all information requested and complete the section that corresponds with your current status.

- Retired (Section 1)
- Military Service (Section 2)
- Voluntary Services (Section 3)
- Inactive (Section 4)
- Disabled (Section 5)

SECTION 1 - RETIRED STATUS

Your license must be current at the time of application. You are required to submit payment of the current (active license) fee with this application. You can find the fee amount on our fees webpage.

You must document completion of 50 hours of continuing medical education (CME) within the past two years. Documentation certifying compliance with this requirement must be submitted with this application.

Acceptable documents are letters or certificates of attendance that show completion of CME courses, the name of the provider, the name and date of the course, the number of approved CME hours completed and your name as the participant.

If you are engaged in an approved postgraduate training program, or engaged in an approved clinical fellowship program, you must submit a letter from the hospital verifying the beginning and ending dates of training.

If necessary, you may need to contact your CME provider to obtain documents verifying your participation. Please send copies of your documents with this application.

SECTION 2 - MILITARY STATUS

A fee is required if you have been discharged from full-time active service or you are still in the military and are canceling your "military" license to restore your license to an active, unrestricted status.

If it has been more than 60 days since your discharge from active service and you have not paid your fees, you will be required to submit payment of any accrued renewal fees and a delinquent fee.

You can find the fee amount on our fees webpage.

Indicate branch of service. (Check one box only.)

☐ Air Force ☐ Army ☐ Marines ☐ Navy ☐ U.S. Public Health Service

Have you been granted a continuing medical education (CME) waiver? ☐ Yes ☐ No

If you were granted a waiver, you must document completion of 50 hours of continuing medical education (CME) within the past two years.

Documentation certifying compliance with this requirement must be submitted with this application.

Acceptable documents are letters or certificates of attendance that show completion of CME courses, the name of the provider, the name and date of the course, the number of approved CME hours completed, and your name as the participant. If you are engaged in an approved postgraduate training program or engaged in an approved clinical fellowship program, you must submit a letter from the hospital verifying the beginning and ending dates of training.

If necessary, you may need to contact your CME provider to obtain documents verifying your participation. Please send in copies of your documents with this application.

MBC USE ONLY

Fee Paid | Receipt # | Date Cashiered | Cashier's Initial

Date Approved | Date Denied | Enforcement Approval Yes ☐ No ☐ Date | Signature

Form RES

SECTION 2 - MILITARY STATUS *continued*

Are you still in the military?

☐ Yes - Please provide expected date of discharge and/or retirement from active service or full-time training:

Expected Date (Month/Day/Year) _____

☐ No - Please provide dates of service or training:

From (Month/Day/Year) _____ To (Month/Day/Year) _____

SECTION 3 - VOLUNTARY SERVICES

Your license must be current at the time of application. You are required to submit payment of the current (active license) fee. You can find the fee amount on our fees webpage.

You must document completion of 50 hours of continuing medical education (CME) within the past two years. Documentation certifying compliance with this requirement must be submitted with this application.

Acceptable documents are letters or certificates of attendance that show completion of CME courses, the name of the provider, the name and date of the course, the number of approved CME hours completed, and your name as the participant. If you are engaged in an approved postgraduate training program or engaged in an approved clinical fellowship program, you must submit a letter from the hospital verifying the beginning and ending dates of training.

If necessary, you may need to contact your CME provider to obtain documents verifying your participation. Please send copies of your documents with this application.

SECTION 4 - INACTIVE STATUS

You must document completion of 50 hours of continuing medical education (CME) within the past two years. Documentation certifying compliance with this requirement must be submitted with this application.

Acceptable documents are letters or certificates of attendance that show completion of CME courses, the name of the provider, the name and date of the course, the number of approved CME hours completed, and your name as the participant. If you are engaged in an approved postgraduate training program or an approved clinical fellowship program, you must submit a letter from the hospital verifying the beginning and ending dates of training.

If necessary, you may need to contact your CME provider to obtain documents verifying your participation. Please send copies of your documents with this application.

If your license is delinquent, you are required to submit payment of any accrued renewal fees, a delinquent fee and penalty fee, if applicable, with this application. You can find the fee amount on our fees webpage.

SECTION 5 - DISABLED STATUS

A licensee who has been granted a license under disabled status shall not engage in the practice of medicine until they do the following:

- Establishes to the satisfaction of the Board under penalty of perjury that the licensee's disability either no longer exists or does not affect their ability to practice medicine safely; or agrees under penalty of perjury to limit their practice in the manner prescribed by their reviewing physician.
- Payment of the current (active license) fee must be submitted with this application. You can find the fee amount on our fees webpage.
- Document completion of 50 hours of continuing medical education (CME). Documentation certifying compliance with this requirement must be submitted with this application. Acceptable documents are letters or certificates of attendance that show completion of CME courses, the name of the provider, the name and date of the course, the number of approved CME hours completed, and your name as the participant. If you are engaged in an approved postgraduate training program or engaged an approved clinical fellowship program, you must submit a letter from the hospital verifying the beginning and ending dates of training.

  If necessary, you may need to contact your CME provider to obtain documents verifying your participation. Please send copies of your documents with this application.

Are you applying to restore your license to:
(Check one box only)

☐ Active Unrestricted Status

☐ Active Status with Limitations on Practice (Describe below)

Please describe specific practice limitations (e.g., no surgery):

SECTION 5 - DISABLED STATUS *continued*

Approximate date disability began: (Month/Day/Year) _____

Duration of disability: ☐ Temporary ☐ Permanent

Will you be practicing medicine: ☐ Full-Time ☐ Part-Time

Activities in medicine:

Check the appropriate box on each line to indicate hours per week for each of the following activities.

	None	1-9	10-19	20-29	30-39	40 or more
Patient Care	☐	☐	☐	☐	☐	☐
Research	☐	☐	☐	☐	☐	☐
Teaching	☐	☐	☐	☐	☐	☐
Administration	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

NOTE TO ATTENDING PHYSICIAN: The applicant's license status is "disabled". The applicant documented the inability to practice medicine due to a disability or illness. The applicant is now requesting to be removed from "disabled" status and to be permitted to practice medicine. Under state law, the applicant must establish to the satisfaction of the Board that the illness or disability no longer exists or does not affect the applicant's ability to practice medicine safely. **As the applicant's attending physician, please provide the information requested below. If additional space is needed, please include an attachment.**

In the space below, please provide a summary of the applicant's case history, including the diagnosis or description of the applicant's disability. Indicate whether you have reviewed the applicant's medical records related to their disability

In the space below, please provide a summary of the applicant's current state of health, including any changes in their health that now enables the applicant to return to the practice of medicine. Please describe the applicant's course of treatment, if applicable for the type of disability or illness.

Does the applicant's current state of health prevent the applicant from practicing medicine safely? ☐ Yes ☐ No

If yes, please explain in the space below.

If the applicant requires any limitations or has agreed to limit their practice, please describe all recommended practice limitations and how those limitations permit the applicant to practice medicine safely. Please also describe specific practice limitations (e.g., no surgery).

SECTION 5 - DISABLED STATUS *continued*

Attending Physician's Name/Specialty | **Telephone Number**

Attending Physician's Address | **City** | **State** | **Zip**

I certify under penalty of perjury under the laws of the State of California that the information I have provided in this application, including supporting documents, is true and correct and that I am licensed to practice in the United States of America.

Attending Physician's Signature | **Date**

Attending Physician's License Number | **Attending Physician's State of Licensure**

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. You must disclose, if since your last renewal, you have had any license disciplined by a government agency, or have been convicted of, or pled guilty, to any crime. Do not list charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions two years or older under California Health and Safety Code Sections 11357(b), (c), (d), (e), or section 11360(b).

"Conviction" includes a plea of no contest and any conviction that has been set aside or deferred pursuant to Penal Code section 1000 or 1203.4, including infractions, misdemeanor, and felonies.

You do not need to report a conviction for an infraction with a fine of less than $300.00 unless the infraction involved alcohol or controlled substances. You must, however, disclose any conviction for which you entered a plea of no contest and any convictions that were subsequently set aside pursuant to Penal Code sections 1000 or 1203.4.

"License" includes permits, registrations, and certificates. "Discipline" includes, but is not limited to, suspension, revocation, voluntary surrender, probation, or any other restrictions. 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 1- 9 requires a signed and dated written explanation. The Explanation for Application Question (Form EXP) may be used to provide your explanation.

1. Since you last renewed your license, have you withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason? ☐ Yes ☐ No
2. Since you last renewed your license, have you been denied a license to practice medicine or is any denial pending against you? ☐ Yes ☐ No
3. Since you last renewed your license, have you 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
4. Since you last renewed your license, have you surrendered a license to practice medicine or have you ever had any license to practice medicine revoked, suspended, or placed on probation? ☐ Yes ☐ No
5. Since you last renewed your license, have you 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
6. Since you last renewed your license, have you ever been charged with, or been found to have committed unprofessional conduct, professional competence, gross negligence, or repeated negligent acts by any medical licensing board or hospital? ☐ Yes ☐ No
7. Since you last renewed your license, have you ever resigned from a medical staff in lieu of disciplinary or administrative action or is any disciplinary action pending against your hospital or staff privileges? ☐ Yes ☐ No
8. Since you last renewed your license, have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed? ☐ Yes ☐ No
9. Since you last renewed your license, have you ever had any healing arts license or certificate disciplined by any state, federal, or foreign jurisdiction? ☐ Yes ☐ No

PRACTICE IMPAIRMENT OR LIMITATIONS

Important: The Board recognizes that healthcare providers encounter health conditions, including those involving physical, mental, and substance use disorders, just as their patients and clients do. In addition to providing care for others, the Board encourages and expects its licensees to also seek care for their own health needs and recognizes that doing so is critical to consumer safety and helps sustain California's healthcare workforce.

An affirmative answer to the question 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 10 requires a signed and dated written explanation. The Explanation for Application Question (Form EXP) may be used to provide your explanation.

10. Are you currently suffering from any condition that impairs your judgment or otherwise adversely affects your ability to practice medicine safely, that is, in a competent, ethical, and professional manner? You may answer "No" if you have any condition that does not impair your ability to practice medicine safely or if you are receiving appropriate treatment for a condition, and due to that treatment, the condition does not impair your ability to practice medicine safely. ☐ Yes ☐ No

FINANCIAL INTEREST

California's Financial Interest Disclosure law (Business and Professions Code section 2426) requires you to disclose any financial interest that you or your immediate family members may have in specified health-related facilities. This information will be available to other government agencies and public and private third-party payers.

Financial interest includes any type of ownership interest including share or stock ownership, limited partnership interest, debt, loan, lease, compensation, remuneration, general or limited partnership interest, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment of money or anything else of value to a licensee or the licensee's immediate family from a health-related facility.

Health-related facility means any facility that provides clinical laboratory services, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, diagnostic imaging, or outpatient surgery centers. Diagnostic imaging includes all X-ray, computed axial tomography, magnetic resonance imaging, nuclear medicine, positron emission tomography, mammography and ultrasound goods and services.

A financial interest does not include the ownership of corporate investment securities, including shares, bonds, or other debt instruments that (1) are purchased from a licensed securities broker on terms available to the general public through a licensed securities exchange or NASDAQ, (2) do not base any profit distributions or other transfers of value on the licensee's referral of patients, (3) do not have a separate class or accounting for any persons or licensees who may make patient referrals to the corporation, and (4) are in a corporation that has total gross assets exceeding $100,000,000.

Do you have financial interest to report? ☐ Yes* ☐ No

***If you answered "yes" to having financial interest to report, please list the name(s) and address(es) of each health-related facility in which you or your immediate family have a financial interest.**

Health-Related Facility Name(s)	Facility's Address

I certify under penalty of perjury under the laws of the State of California that I read and understand the information defining financial interest and that either I have disclosed on this application the names of those health-related facilities in which I or my immediate family have a financial interest, or I do not have any financial interest to disclose.

Applicant's Signature **Date**

DECLARATION

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

I, declare 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. 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's Signature **Date**