MEDICAL BOARD OF CALIFORNIA
Licensing Program

APPLICATION

(Please Check All That Apply)

☐ **Physician's and Surgeon's License**
☐ **Postgraduate Training Authorization Letter (PTAL)**
☐ **Update Application: ATS #_____**
☐ **Limited Practice License**

(Please Check One)

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

Type or Print Legibly

PERSONAL INFORMATION

MBC Use Only

1. Legal Name	Last	First	Middle	
2. Other Names/Alias				
3. United States Social Security Number		**4. Gender** ☐ Male ☐ Female		
5. Date of Birth (mm/dd/yyyy)		**6. Place of Birth** (City, State/Country)		
7. Public/Mailing Address **If you are using a P.O. Box please include a confidential street address on a separate sheet of paper. The address of record will be posted on the Medical Board's Web site once you have obtained a license.**	Mailing Address *(30 characters maximum per line, including spaces)*			
	Mailing Address continued *(30 characters maximum per line, including spaces)*			
	City	State/Province	Zip/Postal Code	Country
8. Telephone Numbers	Home #	Work #	Cell #	
9. E-mail Address				

Personal Information ❑

10. Have you ever filed an application for a Physician's and Surgeon's License or a PTAL in California that has been withdrawn, abandoned, or denied? ☐ Yes ☐ No ❑

11. Have you previously held a Physician's and Surgeon's License in California? If yes, please provide license number: _____ Expired: _____ ☐ Yes ☐ No **Prev License** ❑

EXAMINATIONS

Exams

12. Have you ever been found to have engaged in irregular behavior during an examination? ☐ Yes ☐ No ❑

13. Have you ever been subject to an investigation by an examination entity? ☐ Yes ☐ No ❑

14. Are you certified by the Educational Commission for Foreign Medical Graduates? If yes, please provide the Certificate Issue Date: _____ ☐ Yes ☐ No ❑

15. List all of the following examinations you have taken: **USMLE, FLEX, NBME, LMCC and/or STATE BOARDS** (Use the *Addendum to Question #15 Form* if additional space is needed)

Examination	Date (mm/yyyy)	Result (Pass/Fail)	
			❑
			❑
			❑
			❑
			❑

Cashiering Use Only	School Code	
		L1A

2005 Evergreen Street, Suite 1200, Sacramento, CA 95815-3831 (916) 263-2382 (800) 633-2322 FAX: (916) 263-2487 www.mbc.ca.gov

MEDICAL EDUCATION

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NOTE: To be eligible for a PTAL or License, all schools attended must be on the Board's list of recognized or approved medical schools. If you did not attend or graduate from a recognized or approved medical school you may be eligible for licensure pursuant to Section 2135.7 of the Business and Professions Code (effective 1/2013). To view the Board's list, please refer to our website at: http://www.mbc.ca.gov/Applicants/Medical_Schools/Schools_Recognized.aspx.

16. List each medical school that you have attended.

Medical School Name	Mailing Address	Attendance Dates (mm/dd/yyyy)		L2 ❑ Trans ❑ School Code
		Start		
		End		
		Start		❑ ❑
		End		
		Start		❑ ❑
		End		

17. School of Graduation	Title of Degree Awarded	Issue Date of Degree (mm/dd/yyyy)	Diploma ❑

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

Unusual Circumstances

18. Did you ever take a leave of absence during medical school?	☐ Yes ☐ No	❑
19. Were you ever placed on probation?	☐ Yes ☐ No	❑
20. Were you ever disciplined or placed under investigation?	☐ Yes ☐ No	❑
21. Were any negative reports ever filed by your instructors?	☐ Yes ☐ No	❑
22. Were any limitations or special requirements imposed on you because of questions of academic or disciplinary problems, or for any other reason?	☐ Yes ☐ No	❑

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

Postgraduate Training

23. Have you participated in any ACGME-accredited postgraduate training in the United States or RCPSC-accredited postgraduate training in Canada? ***List every program in which you have participated or are currently participating, regardless of whether the program was completed or any credit was granted.***
(Use the *Addendum to Question #23 Form* if additional space is needed)

(*If NO please skip to question # 33*) ☐ Yes ☐ No ❑

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

APPLICANT: (Print Name)

DATE OF BIRTH: (mm/dd/yyyy)

L1B

A "yes" response to questions 18-22 requires a signed and dated written explanation.

UNUSUAL CIRCUMSTANCES DURING POSTGRADUATE TRAINING

		MBC Use Only
24. Have you ever received partial or no credit for a postgraduate training program?	☐ Yes ☐ No	❑
25. Have you ever taken a leave of absence or break from your training?	☐ Yes ☐ No	❑
26. Have you ever been terminated, dismissed or expelled from a program?	☐ Yes ☐ No	❑
27. Have you ever resigned from a program?	☐ Yes ☐ No	❑
28. Were you ever placed on probation for any reason?	☐ Yes ☐ No	❑
29. Were you ever disciplined or placed under investigation?	☐ Yes ☐ No	❑
30. Were any incident reports ever filed by instructors?	☐ Yes ☐ No	❑
31. Were any limitations or special requirements placed upon you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	☐ Yes ☐ No	❑
32. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	☐ Yes ☐ No	❑

MEDICAL LICENSE

		License
33. Have you ever held, or do you currently hold a medical license in any U.S. state, U.S. territory or Canadian province? ***List medical license information below. It is not necessary to list temporary, training, or provisional licenses.*** (Use the *Addendum to Question #33 Form* if additional space is needed)	☐ Yes ☐ No	❑

State/Province	License Number	Issue Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	Dates of Practice (mm/yyyy to mm/yyyy)	
					❑
					❑
					❑
					❑
					❑

ABMS CERTIFICATION

		ABMS
34. Are you currently certified by a Member Board of the American Board of Medical Specialties?	☐ Yes ☐ No	❑

Member Board	Certificate Number	Expiration Date (mm/yyyy)

35. Has your certification ever been suspended or revoked?	☐ Yes ☐ No	❑
36. Is there any action currently pending against you?	☐ Yes ☐ No	❑

APPLICANT: (Print Name)	DATE OF BIRTH: (mm/dd/yyyy)	L1C

A "yes" response to questions 24-32 and 35-36 requires a signed and dated written explanation.

DEA CERTIFICATION

MBC Use Only

		MBC Use Only
37. Are you currently registered with the Drug Enforcement Agency (DEA)?	☐ Yes ☐ No	DEA ❑

DEA Number	State of Issue	Expiration Date (mm/yyyy)	
			❑
			❑

38. Have your DEA privileges ever been denied, suspended, restricted, or terminated?	☐ Yes ☐ No	❑
39. Have you ever entered into any arrangement, agreement or plea in lieu of federal prosecution with the DEA to resolve an alleged violation of a federal or state drug statute or regulation?	☐ Yes ☐ No	❑

MALPRACTICE HISTORY

		Malpractice History
40. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement?	☐ Yes ☐ No	❑
41. Has a judgment or arbitration ever been awarded in the amount of $30,000 or more?	☐ Yes ☐ No	❑

DISCIPLINARY HISTORY

Disciplinary History

These questions refer to discipline by any hospital, Military or Public Health Service, State Board, or other Governmental Agency of any U.S. state or territory, Canadian province, or foreign country.

42. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?	☐ Yes ☐ No	❑
43. Have you ever been denied a license to practice medicine?	☐ Yes ☐ No	❑
44. Is any denial pending against you?	☐ Yes ☐ No	❑
45. Have you ever had any license to practice medicine subjected to any disciplinary action?	☐ Yes ☐ No	❑
46. Is any disciplinary action pending against any of your licenses to practice medicine?	☐ Yes ☐ No	❑
47. Have you ever surrendered a license to practice medicine?	☐ Yes ☐ No	❑
48. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	☐ Yes ☐ No	❑
49. 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	❑
50. 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	❑
51. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?	☐ Yes ☐ No	❑
52. Is any disciplinary action pending against your hospital or staff privileges?	☐ Yes ☐ No	❑
53. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?	☐ Yes ☐ No	❑
54. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?	☐ Yes ☐ No	❑

APPLICANT: (Print Name)	**DATE OF BIRTH:** (mm/dd/yyyy)	**L1D**

A "yes" response to questions 38-54 requires a signed and dated written explanation.

CRIMINAL RECORD HISTORY

MBC Use Only

Applicants who answer "NO" to the questions below, but have a previous conviction or plea, may have their application denied for knowingly falsifying the application. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application.

For each conviction disclosed, you must submit certified copies of the arresting agency report, certified copies of the court documents, including a plea form and court docket, and a signed and dated descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of the incident and all circumstances surrounding the incident). If the documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is required. In addition, you may submit evidence of rehabilitation.

Criminal History

55. Have you ever been convicted of, or pled guilty or nolo contendere to **ANY** offense in the United States, its territories, or a foreign country? ***This includes every citation, infraction, misdemeanor and/or felony, including traffic violations. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code sections 11357(b), (c), (d), (e), or section 11360(b) which are two years or older should NOT be reported. Convictions that were later expunged from the record of the court or set aside pursuant to section 1203.4 of the California Penal Code or equivalent non-California law MUST be disclosed.***	☐ Yes ☐ No	❑
56. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357(b), (c), (d), (e), or section 11360(b) which are two years or older, have you had a charge or conviction that was set aside or later expunged from the record of the court?	☐ Yes ☐ No	❑
57. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?	☐ Yes ☐ No	❑
58. Are you a registered sex offender?	☐ Yes ☐ No	❑

PRACTICE IMPAIRMENT OR LIMITATIONS

If you give an affirmative answer to any of the questions below, 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. Please refer to the *Application Information for a Limited Practice License* for further information.

Limitations

59. Have you ever been enrolled in, required to enter into, or participated in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?	☐ Yes ☐ No	❑
60. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?	☐ Yes ☐ No	❑
61. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice medicine safely?	☐ Yes ☐ No	❑
62. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice medicine safely?	☐ Yes ☐ No	❑
63. Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?	☐ Yes ☐ No	❑
64. Do you suffer from a progressive disorder or a health condition that will likely result in a general decline in health or function that may impair or limit your ability to practice medicine safely?	☐ Yes ☐ No	❑

APPLICANT: (Print Name)	**DATE OF BIRTH:** (mm/dd/yyyy)	**L1E**

A "yes" response to questions 55-64 requires a signed and dated written explanation.

PHOTOGRAPH

MBC Use Only

Photograph

Affix a 2" X 2" Photo Here

Photo Must Be Recent and Must Be of your Head and Shoulder Areas Only

Altered Photographs 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. The Chief of the Licensing Program is the custodian of records.

Photograph ❑

DECLARATION

Applicant Name & DOB ❑

The applicant, _____, _____,
Please print full name (First, Middle, Last) **Date of Birth (mm/dd/yyyy)**
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; 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 ❑

SIGNATURE:_____**DATE:**_____

NOTARY SECTION

Applicant Signature ❑

SIGNATURE OF APPLICANT: _____
(**DO NOT SIGN EXCEPT IN THE PRESENCE OF NOTARY** – Please sign full name)

State of _____

County of _____

Applicant Name & Notary Date ❑

Subscribed and sworn to (or affirmed) before me on this _____ day of _____, 20_____,

by, _____ proved to me on the basis of satisfactory evidence
(**Print applicant's name**)

to be the person who appeared before me.

NOTARY SEAL

Notary Signature & Seal ❑

_____
SIGNATURE OF NOTARY PUBLIC

L1F