MEDICAL BOARD OF CALIFORNIA
Licensing Program

CURRENT POSTGRADUATE TRAINING ENROLLMENT

Check one: ☐ **U.S. or Canadian Medical School Graduate** ☐ **International Medical School Graduate**

Type or Print Legibly

APPLICANT INFORMATION

NAME: Last First Middle

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Medical School of Graduation

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

Facility Name			
Facility Address			
Specialty Area		**ACGME 10-digit Program #** http://www.acgme.org/adspublic	__ __ __ __ __ __ __ __ __ __
Dates of Training (mm/dd/yyyy)	Start Date: __ __ / __ __ / __ __ __ __	Anticipated Completion Date: __ __ / __ __ / __ __ __ __	

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

NOTE: The completed Form L4 must be mailed directly from the program to the Board to be acceptable.

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 or the RCPSC to offer the type and level of training to the above named applicant and that the applicant is actively participating in a slotted position in an accredited ACGME or RCPSC postgraduate training program.

PRINT NAME OF PROGRAM DIRECTOR **Email Address**

SIGNATURE OF PROGRAM DIRECTOR **DATE** **Phone Number**
(Signature Stamp Is Not Acceptable)

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only the Program Director may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

NOTE: If a hospital seal is not available, the program director shall also sign in the section below in the presence of a notary public.

SIGNATURE OF PROGRAM DIRECTOR: _____
(Please sign full name in presence of notary)

State of _____

County of _____

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

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

to be the person who appeared before me.

SIGNATURE OF NOTARY PUBLIC

HOSPITAL or NOTARY SEAL

MBC Use Only

Personal Data ☐

Program Verified ☐

Program Director's Signature & Date ☐

Program Director's Signature ☐

Notary Signature & Seal ☐

Hospital Seal ☐

L4

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