Medical Board of California

Postgraduate Training License Enrollment Form

The current program director must complete and submit Form EF verifying that the applicant for a postgraduate training license is currently enrolled or will be enrolled in a California ACGME-accredited postgraduate training program.

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

MBC USE ONLY

APPLICANT INFORMATION

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

Medical School ○

Full Legal Name

Full Last Name	First Name	Middle Name	Suffix

Applicant Information ○

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

PROGRAM DIRECTOR TO COMPLETE ACGME TRAINING INFORMATION

Note: The start date of clinical training should not include time spent in non-clinical orientation. A signed and dated letter of explanation listing detailed information including dates is required if the anticipated end date includes research years and/or the program length is longer than what is reflected on ACGME's website. The postgraduate training license will only be valid during research years that occur in the middle of the clinical training required for licensure AND if the resident remains enrolled in the ACGME-accredited program when conducting research.

Facility Name Required

Verified Program Information ○

Facility Address Required

Specialty Required

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

Specialty/ ACGME # ○

Dates of Clinical Training

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

Dates of Training ○ ○

Program Type ☐ **Transitional** ☐ **Preliminary/Internship** ☐ **Categorical** ○

Will the resident be completing research during training that requires them to take a break from training, a leave of absence, change the anticipated clinical training end date, and/or no longer be enrolled in the program? ☐ Yes ☐ No ○

If "Yes", please complete the Research Period Questionnaire, Form RES1-RES2.

RESIDENT INFORMATION

Full Legal Name

Full Last Name	First Name	Middle Name	Suffix

MBC USE ONLY

Applicant Name ○

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

The program director or the designated institutional official (DIO) must sign this form. If the program director or the DIO is delegating 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. **If the resident moves, transfers to another program, is terminated, resigns, or takes a leave of absence resulting in a change to the PTL expiration date, the program director must submit a Program Status Update/Change Form directly to the Board within 30 days.**

Verified PD ○

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 and that the applicant is/will be participating in a slotted position in an ACGME-accredited postgraduate training program during the dates listed above.

Staff Initials & Date

PRINTED NAME OF PROGRAM DIRECTOR OR DIO

SIGNATURE OF PROGRAM DIRECTOR OR DIO
(Signature stamps are not acceptable)

DATE

Program Director/ DIO's Signature & Date ○

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 if you are submitting the form by mail.

SIGNATURE OF PROGRAM DIRECTOR OR DIO: _____

(SIGN IN PRESENCE OF NOTARY)

Program Director/ DIO's Signature ○

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 based on satisfactory evidence to be the person who appeared before me.

(PROGRAM or NOTARY SEAL)

Notary Signature & Seal ○

Program Seal ○

Docs ○

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 with the Board or by mail to be acceptable

Form **EF2**