MEDICAL BOARD OF CALIFORNIA
Licensing Program

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

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

Type or Print Legibly

APPLICANT INFORMATION

LEGAL NAME: **Last** **First** **Middle** **Suffix**

Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School of Graduation

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

Facility Name			
Facility Address			
Specialty		**ACGME 10-digit Program #** https://apps.acgme.org/ads/Public	
Dates of Training (mm/dd/yyyy)	Start Date:	End Date (or anticipated completion date):	

UNUSUAL CIRCUMSTANCES

***Program Director*: Please provide a signed and dated letter of explanation, including dates, for any "yes" response to questions # 1-7. The explanation must be provided on program letterhead and mailed directly to the Board with the Form L3A-L3B.**

1. Did the applicant receive partial or no credit during his/her postgraduate training?	☐ Yes ☐ No
2. Did the applicant ever take a leave of absence or break from his/her training?	☐ Yes ☐ No
3. Was the applicant ever terminated, dismissed or expelled?	☐ Yes ☐ No
4. Was the applicant ever placed on probation?	☐ Yes ☐ No
5. Was the applicant ever disciplined or placed under investigation?	☐ Yes ☐ No
6. Were any limitations or special requirements placed upon the applicant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	☐ Yes ☐ No
7. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year?	☐ Yes ☐ No

GENERAL MEDICINE TRAINING REQUIREMENT

8. Did the applicant complete a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC?	☐ Yes ☐ No

To qualify for licensure in California, applicants who are graduates of an international medical school must complete **at least four (4) months** of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete **four (4) months** of training in GENERAL MEDICINE prior to licensure. *The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant had direct patient care responsibilities for at least four months in any particular specialty or sub-specialty area.*

MBC Use Only

Applicant Information ☐

Verified Program Information ☐

☐ ☐

Unusual Circumstance

☐ ☐ ☐ ☐ ☐ ☐ ☐

Gen Med Required ☐

L3A

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

APPLICANT INFORMATION

LEGAL NAME: **Last** **First** **Middle** **Suffix**

MBC Use Only

Applicant's Name ❑

ATTENTION: PROGRAM DIRECTOR

<u>Do not sign and date this form prior to the last day of any postgraduate training year which will be used by the applicant to qualify for licensure.</u> Completion of this form will certify that the applicant has satisfactorily completed a period of accredited postgraduate training at this facility and that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

THE PERSON WHO SIGNS THIS FORM <u>MAY NOT</u> 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.

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

The program director signing this form is formally certifying and documenting under penalty of perjury that the applicant received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to satisfactory performance. The program director is attesting to the fact that the applicant has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Verified PD Staff Initials & Date

I hereby declare under penalty of perjury under the laws of the State of California that all of the information contained on these forms 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 completed by the applicant named on the Form L3A, and the applicant was trained in an ACGME or RCPSC slotted program position.

Program Director's Signature & Date ❑

_____
PRINTED NAME OF PROGRAM DIRECTOR

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

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.**

Program Director's Signature ❑

SIGNATURE OF PROGRAM DIRECTOR: _____
(SIGN FULL 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 _____

Notary Signature & Seal ❑

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)

Hospital Seal ❑

to be the person who appeared before me.

HOSPITAL or NOTARY SEAL

_____
SIGNATURE OF NOTARY PUBLIC

L3B

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