Osteopathic Medical Board of California
1300 National Drive, Suite 150
Sacramento, CA 95834
(916) 928-8390 Fax (916) 928-8392
www.osteopathic.ca.gov www.ombc.ca.gov

APPLICATION FOR OSTEOPATHIC POSTGRADUATE TRAINING LICENSE

To be eligible for a postgraduate training license, you must not be fully licensed in another state or not have completed 36 months of postgraduate training, 24 months in the same program and you must be enrolled in an accredited postgraduate training rotation in California. Please read all instructions prior to completing this application. All questions must be answered. If something is not applicable write N/A, do not leave it blank. In addition to this form, other essential application requirements must be completed. FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

PERSONAL INFORMATION

1. NAME: Last:	First:	Middle:
OTHER NAMES USED if any:	2. Social Security No. or Individual Taxpayer ID. No.	

3. DATE OF BIRTH	4. PLACE OF BIRTH	5. GENDER: ☐ Male ☐ Female
		☐ Male ☐ Female

6. Confidential Mailing Address (For Board use only) Street,	City,	State,	Zip Code
Address of Record (Public Address) Street	City,	State,	Zip Code

7. CONTACT INFORMATION FOR APPLICATION PROCESS:

Daytime Phone Number	E-mail

8. PRE-OSTEOPATHIC COLLEGES	ADDRESS (street, city ,state, zip code)	Dates of Attendance (mm/dd/yyyy)

TITLE OF DEGREE AWARDED:	ISSUANCE DATE OF DEGREE AWARDED (mm/dd/yyyy)

9. OSTEOPATHIC COLLEGE(S)	ADDRESS (street, city ,state, zip code)	DATES OF ATTENDANCE (mm/dd/yyyy)

TITLE OF DEGREE AWARDED:	ISSUANCE DATE OF DEGREE AWARDED (mm/dd/yyyy)

10. POSTGRADUATE TRAINING IN CALIFORNIA IN WHICH YOU ARE CURRENTLY OR WILL BE ENROLLED.

INTERNSHIP Hospital Name	Address (street, city, state, zip code)	Specialty	Dates of Attendance (mm/dd/yyyy)

RESIDENCY/FELLOWSHIP: Hospital Name	Address (street, city ,state, zip code)	Specialty	Dates of Attendance (mm/dd/yyyy)

11.PRIOR POSTGRADUATE TRAINING YOU HAVE ATTENDED OR COMPLETED (internship, residency, fellowship)

Hospital Name	Address (street, city ,state, zip code)	Type of Service	Dates of Attendance Mm/dd/yyyy)

12. BOARD CERTIFIED: ☐ Yes ☐ No NAME OF CERTIFYING BOARD	DATE CERTIFIED: (mm/dd/yyyy)
☐ Yes ☐ No	
13. LIST ALL WRITTEN EXAMINATIONS PASSED	DATE COMPLETED (mm/dd/yyyy)

14. LIST ALL STATES IN WHICH YOU ARE CURRENTLY LICENSED OR HAVE EVER BEEN LICENSED TO PRACTICE OSTEOPATHIC MEDICINE. *written examination, reciprocity, National Boards, etc.

STATE	DATE LICENSED	*HOW LICENSED	LICENSE NUMBER

15. Are you serving, or have you previously served in the Military? ☐ Yes ☐ No

16. Are you married to, or in a domestic partnership or other legal union, with an active duty member of the U.S. military assigned to duty in California? ☐ Yes ☐ No

17. Do you currently have asylum status? ☐ Yes ☐ No

For any "Yes" answers to the following questions requires a written explanation that is signed and dated and identifies each question being answered. Submit written explanation as a separate attachment with application. ☐ Yes ☐ No

18. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program? If yes, attach explanation**.** ☐ Yes ☐ No

19. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgment or arbitration award of over $30,000.00? ☐ Yes ☐ No

20. Has there ever been any peer group or professional association inquiry or action involving your practice or relationship with patients alleging unprofessional conduct, wrongdoing or negligence? ☐ Yes ☐ No

21. Have you ever withdrawn an application from any hospital, public entity or licensing agency?

☐ Yes ☐ No

If Yes, When? (please explain on separate attachment or where space provided)

22. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed for medical disciplinary case, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending? ☐ Yes ☐ No

23. Have you ever had a medical or any healing art license restricted, suspended, revoked, surrendered, disciplined or denied in any state? ☐ Yes ☐ No

24. Have you ever been denied permission to practice medicine or any healing art in any state?

☐ Yes ☐ No

25. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following? ☐ Yes ☐ No

IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:

☐ A condition which required admission to an inpatient psychiatric treatment facility Alcohol
☐ or chemical substance dependency or addiction
☐ Emotional, mental or behavioral disorder Other
☐ (explain)

FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.

If necessary, add further explanation for above questions below or include additional information in a separate attachment. Please include question number with each answer.

Explanation questions 18- 25

Explanation questions 18- 25

ATTENTION: This application is not complete, you must download the application, sign the application in the presence of a notary public and submit a hard copy of the application that is signed and notarized and mail to OMBC. Faxes will not be accepted.

Paste a recent 2" X 2" (approximate size) Photo must be of your head and shoulder area only CCR 1613.

NOTICE OF COLLECTION OF PERSONAL INFORMATION

Agency requesting information: Osteopathic Medical Board of California, 1300 National Drive, Suite 150, Sacramento, CA 95834, (916) 928-8390. The information requested herein is mandatory, unless otherwise indicated, and is maintained by the Osteopathic Medical Board of California (Board), 1300 National Drive, Suite 150,Sacramento, California 95834, Executive Officer, (916) 928-8390, in accordance with Business & Professions Code section 3600 et seq. Disclosure of your individual taxpayer identification number or social security number is mandatory and collection is authorized by Section 30 of the Business & Professions Code. Failure to provide all or any part of the requested mandatory information will result in the rejection of your application as incomplete. Except for the individual taxpayer identification number or social security number, the information requested will be used to identify and evaluate applicants for licensure, issue and renew licenses, and enforce licensing standards set by statutes and regulations. Your individual taxpayer identification number or social security number will be used exclusively for tax enforcement purposes, compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or verification of licensure or examination status by a licensing or examination board where licensing is reciprocal with the requesting state. It will not be deemed to be a public record and will not be disclosed to the public. If you fail to disclose your individual taxpayer identification number or social security number you will be reported to the Franchise Tax Board (FTB), which may assess a $100 penalty against you. Upon request, the Board will provide the FTB with your name, address(es) of record, individual taxpayer identification number or social security number, type of license and status, and effective date and expiration date of your license or renewal. You have the right to review your personal information maintained by the agency unless the records are exempt from disclosure. Please note that certain information you provide may be disclosed under some circumstances, such as: in response to a Public Records Act (PRA) request (beginning with Government Code section 6250), to another government agency as required by state or federal law, or in response to a court or administrative order, subpoena, or search warrant.

APPLICANT CERTIFICATION AND DECLARATION

I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND CORRECT. Further, I further hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past or present), or business and professional associates (past or present, and future), and all government agencies (local, state, federal) to release to the Osteopathic Medical Board of California 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 the 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 UNDERSTAND THAT ANY OMISSION, FALSIFICATION, OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

_____ _____

(Signature of applicant—signed in presence of notary public) Date

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 _____

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

By, _____ proved to me on the basis of satisfactory evidence to be the person who appeared before me.
(Print Applicant's Legal Name)

_____
(Signature of Notary Public)

NOTARY SEAL

_____
(Notary Address)

_____
(Notary Address line 2)

My Commission expires_____