OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
1300 National Drive, Suite 150
Sacramento, CA 95834
(916) 928-8390 Fax (916) 928-8392
osteopathic@dca.ca.gov www.ombc.ca.gov

POSTGRADUATE TRAINING PROGRAM ENROLLMENT CERTIFICATION FORM

NOTE: If the trainee moves, or transfers to another program, is terminated, resigns, or takes a leave of absence, a Program Status/Change Form is required to be completed and submitted by the program director and sent directly to the Board.

APPLICANT INFORMATION

Name: Last	First	Middle	Suffix

Date of Birth (mm/dd/yyyy)	Last 4 digits of SSN or ITIN	Osteopathic Medical School of Graduation

PHOTO AREA
Past a recent 2" X 2"
(approximate size)
Photo must be of your
head and shoulder area.

_____

APPLICANT SIGNATURE

PROGRAM DIRECTOR TO COMPLETE AOA OR ACGME TRAINING INFORMATION

Facility Name

Facility Address (Street)	City	State	Zip Code

Specialty:	Please list accreditation (AOA or ACGME) and number

Dates of Training: Start Date: (mm/dd/yyyy)	End Date: (mm/dd/yyyy)

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

NOTE: Only the program director may sign this form. If the trainee takes a leave of absence, resigns, exits, or transfers to another program, please submit a Program Status Update/Change Form directly to the Board.

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 AOA or ACGME 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 AOA or ACGME postgraduate training program.

_____
Print name of program director

_____ _____
Signature of program director Date
(Signature Stamp is not Acceptable)

NOTE: Place program seal below as indicated. If a program seal is not available, the program director shall sign in the presence of a notary public and have notary complete and place seal in box below.

PROGRAM DIRECTOR SIGNATURE: _____
(Sign Full Name in the Presence of Notary Public)

A notary public or other officer completing this certificate verifies only the identity of the individual who signs the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that documents.

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 Program Director's Name)

_____
(Signature of Notary Public)

PROGRAM OR NOTARY SEAL

NOTE: The completed form(s) must be mailed directly from the program to the Board to be acceptable. Mail to Osteopathic Medical Board of California, 1300 National Drive, Suite 150, Sacramento, CA 95834.