Application Summary

License Type:	**Physician's and Surgeon's**
Application:	**Physician's and Surgeon's - Initial Application**
Application Number:	**14655418**
Application Date:	**05/04/2019 (mm/dd/yyyy)**

Application Questions

Are you applying with an Individual Taxpayer Identification Number (ITIN)?	[redacted]
Have you served or are you currently serving in the military?	
Are you requesting expediting of this application for spouses or domestic partners of an active duty member of the U.S. Armed Forces?	
Are you requesting expediting of this application for honorably discharged members of the U.S. Armed Forces?	
Are you requesting expediting of this application to practice in a medically underserved area or population?	
Are you currently enrolled in an ACGME/RCPSC-accredited postgraduate training program in the United States or Canada?	**Yes**

Personal Detail

First Name:	**Joshua**
Last Name:	**Yap**
Birthdate:	**/**/****
Gender:	**Male**
SSN/ITIN:	*********

Addresses

License Related Addresses

Address of Record (Required)

Warning: **In order to protect your privacy and identity, address will not be displayed.**

License Attributes Selected

Transaction [redacted]

2170 CA012

Previous Application or License

9. Have you served or are you currently serving in the U.S. Military?	[redacted]
10. Are you requesting expediting of this application as a spouse or domestic partner of an active duty member of the U.S. Armed Forces?	
11. Have you ever filed an application for a Physician's and Surgeon's License or a PTAL in California that has been withdrawn, abandoned, or denied?	
12. Have you previously held a Physician's and Surgeon's License in California?	**No**

Examinations

13. Are you certified by the Educational Commission for Foreign Medical Graduates?	**No**

Examinations 1

Examination:	**United States Medical Licensing Examination (USMLE) Step 3**
Date Passed:	[redacted]

Examinations 2

Examination:	**United States Medical Licensing Examination (USMLE) Step 2CS**
Date Passed:	[redacted]

Examinations 3

Examination:	**United States Medical Licensing Examination (USMLE) Step 2CK**
Date Passed:	[redacted]

Examinations 4

Examination:	**United States Medical Licensing Examination (USMLE) Step 1**
Date Passed:	[redacted]

Education History

Medical School Name	**Loma Linda University School of Medicine**
Mailing Address of the Medical School	**11175 Campus St. Loma Linda, CA 92350**
Attendance Start Date	**08/01/2011 (mm/dd/yyyy)**
Attendance End Date	**05/24/2015 (mm/dd/yyyy)**
Were You Awarded a Degree?	**Yes**
Title of Degree Awarded	**MD - Doctor of Medicine**

h2 trans diploma

CA012

Issue Date of Degree **05/24/2015 (mm/dd/yyyy)**

ACGME or RCPSC Accredited Postgraduate Training Programs

16. Have you participated in any ACGME-accredited postgraduate training in the United States or RCPSC-accredited postgraduate training in Canada? **Yes**

17. Have you ever received partial or no credit for a postgraduate training program?

18. Have you ever taken a leave of absence or break from your training?

19. Have you ever been terminated, dismissed or expelled from a program?

20. Have you ever been placed on probation for any reason?

21. Have you ever been disciplined or placed under investigation?

22. Have you ever had any limitations or special requirements placed upon you for clinical performance professionalism, medical knowledge, discipline, or for any other reason?

23. Have you ever had a postgraduate training program contract not be renewed or offered for a following year?

[redacted]

ACGME or RCPSC Accredited Postgraduate Training Programs 1

Program Facility Name	**Montefiore Medical Center**
City:	**Bronx**
State/Province:	**New York**
Specialty:	**Family Medicine**
Training Start Date:	**07/01/2015 (mm/dd/yyyy)**
Training End Date:	**06/30/2019 (mm/dd/yyyy)**

L3A/B
L9

ACGME or RCPSC Accredited Postgraduate Training Programs 2

Program Facility Name	**Montefiore Medical Center**
City:	**Bronx**
State/Province:	**New York**
Specialty:	**Preventive Medicine**
Training Start Date:	**07/01/2017 (mm/dd/yyyy)**
Training End Date:	**06/30/2019 (mm/dd/yyyy)**

not started

Medical License(s)

24. Have you ever held or do you currently hold a medical license in any U.S. state, U.S. territory, or Canadian province?	**No**

ABMS Certification

25. Are you currently certified by a Member Board of the American board of Medical Specialties?	**No**

Malpractice History

26. Has a claim or an action ever been filed against you for the practice of medicine that resulted in a malpractice settlement, judgement, or arbitration?	[redacted]

Disciplinary History

27. Have you ever had your DEA privileges denied, suspended, restricted, or terminated?	[redacted]
28. Have you ever entered into any arrangement, agreement or plea in lieu of federal prosecution with the DEA to resolve an alleged violation of a federal or state drug statute or regulation?	
29. Have you ever withdrawn an application for medical licensure in lieu of denial, disciplinary action, or for any other similar reason?	
30. Have you ever been denied a license to practice medicine?	
31. Is any denial pending against you?	
32. Have you ever had any license to practice medicine subjected to any disciplinary action?	
33. Is any disciplinary action pending against any of your licenses to practice medicine?	
34. Have you ever surrendered a license to practice medicine?	
35. Have you ever had any license to practice medicine revoked, suspended, or placed on probation?	
36. Have you ever had any license to practice medicine subjected to any action including, but not limited to, informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation?	[redacted]

37. Have you ever been charged with, or been found to have committed unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts by any medical licensing board or hospital?

38. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action?

39. Is any disciplinary action pending against your hospital or staff privileges?

40. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed?

41. Have you ever had any healing arts license or certificate disciplined by another state or federal territory?

Criminal Record History

42. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in the United States, its territories, or a foreign country?

43. Exclusive of juvenile court adjudications and criminal charges dismissed under section 1000.3 of the California Penal Code or equivalent non-California laws, or convictions under California Health and Safety Code section 11357 (b), (c), (d), (e), or section 11360 (b) which are two years or older, have you had a conviction that was set aside or later expunged from the record of the court?

44. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?

45. Are you a registered Sex Offender?

Practice Impairment or Limitations

46. Have you ever been enrolled in, required to enter into, or participated in any drug, alcohol, or substance abuse recovery program or impaired practitioner program?

47. Have you ever been treated for or had a recurrence of a diagnosed addictive disorder?

48. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice medicine safely?

49. Have you ever been diagnosed with a neurological or other physical condition that may impair your ability to practice medicine safely?

50.Do you have any other condition that may in any way impair or limit your ability to practice medicine safely?

51. Do you suffer from a progressive disorder or a health condition that will likely result in a general decline in health or function that may impair or limit your ability to practice medicine safely?

[redacted]

Family Physician Training Program Voluntary Fee

Would you like to contribute?

Attachments

Fees

Application Fee	**$442.00**
Department of Justice (DOJ) Fee	**$32.00**
Federal Bureau of Investigation (FBI) Fee	**$17.00**
50% Initial License Fee	**$391.50**
StephenM.ThompsonLRP	**$25.00**
Total Amount Due:	**$907.50**

Applications are not considered submitted for processing until payment is received.

Attestation

I attest I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorized all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present and future), and all government agencies (local, stated, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that 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 further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.
I understand that falsification or misrepresentation of any item or response on this application or any attachment hereto is a sufficient basis for denying or revoking a license.

Signature: Date:

20950098 AV

PHOTOGRAPH

[redacted]

MBC Use Only

Rev L1A-F Staff Initials & Date: MB 6/31

Photograph ☐

Applicant Name & DOB ☐

Notice: All items in this application are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensing per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

DECLARATION

The applicant, JOSHUA YAP [redacted]
PRINT LEGAL NAME (First, Middle, Last, Suffix) DATE OF BIRTH (mm/dd/yyyy)

being first duly sworn upon his/her oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), or business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, 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 that 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 further authorize the Medical Board of California or its successors to release, in any investigation or proceeding, to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT ANY OMISSION, FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

Applicant Signature & Date ☐

SIGN LEGAL NAME: [signature] DATE: 5/5/19

NOTARY SECTION

Applicant Signature ☐

SIGNATURE OF APPLICANT: [signature]
(SIGN LEGAL 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 New York

County of Bronx

Subscribed and sworn to (or affirmed) before me on this 5th day of May, 2019

by, Joshua Yap proved to me on the basis of satisfactory evidence
(PRINT APPLICANT'S LEGAL NAME)

to be the person who appeared before me.

Applicant Name & Notary Date ☐

[signature]
SIGNATURE OF NOTARY PUBLIC

NOTARY SEAL
ELBA IRIS CARAIO
NOTARY PUBLIC-STATE OF NEW YORK
No. 01CA6070198
Qualified in Bronx County
My Commission Expires 02-25-2022

Notary Signature & Seal ☐

L1F

07A-100 (Revised 01/2019)

MEDICAL BOARD OF CALIFORNIA

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Licensing Program
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
Fax: (916) 263-2487
www.mbc.ca.gov

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

TIMELINE OF ACTIVITIES

A complete timeline of activities from graduation of medical school to present is required. Provide the Board with a written chronological description of all your professional and non-professional activities. Please include a detailed description of your duties and responsibilities for any externship, observership, or volunteer activity in California. Dates shall be reported in chronological order in month/year (mm/yyyy) format. *Please use as many forms as necessary to provide a complete timeline of activities.*

Type or Print Legibly

PERSONAL INFORMATION

LEGAL NAME: Last	First	Middle	Suffix
Yap	Joshua		

Date of Birth (mm/dd/yyyy)	U.S. SSN or ITIN	Medical School of Graduation
[redacted]	[redacted]	Loma Linda University School of Medicine

Start Date	End Date	Location (Provide Facility Name, Address, and Supervisor)	Activities	MBC Use Only
07/2015	06/2019	Montefiore Medical Center 111 E 210th St. Bx, NY 10467 Program Director: Mary Duggan, MD	Residency + Internship for Family + Preventive Medicine	☐
				☐
				☐
				☐
				☐

SIGN LEGAL NAME: [signature] DATE: 5/7/2019

Applicant's signature and date are required.

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CERTIFICATE OF MEDICAL EDUCATION

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
Yap	Joshua		

Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School of Graduation
[redacted]	[redacted]	Loma Linda University

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

NOTE: If the applicant had an accelerated or extended curriculum, withdrew from this institution, or was accepted with advanced standing, a letter of explanation from a school official is required. The letter must be on medical school letterhead, signed by a school official, and be mailed directly to the Board from the medical school.

1. Name of Medical School	Loma Linda University School of Medicine
2. State/Province/Country	California/USA

3. The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 ***years*** of resident instruction, completing at least 4,000 hours, of which at least 80 percent actual attendance is required in the subjects set forth hereunder (Business and Professions Code Sections 2089, 2089.5, 2089.7, 2090, 2091.1, 2091.2).

Alcoholism and Chemical Dependency	Geriatric Medicine	Otolaryngology	Psychiatry
Anatomy	Histology	Pain Management and End-of-Life-Care**	Radiology, including Radiation Safety
Anesthesia	Human Sexuality	Pathology, Bacteriology, and Immunology	Spousal Partner Abuse Detection & Treatment***
Biochemistry	Medicine	Pediatrics	Surgery, including Orthopedic Surgery
Child Abuse Detection and Treatment	Neuroanatomy	Pharmacology	Therapeutics
Dermatology	Neurology	Physical Medicine	Tropical Medicine
Embryology	Obstetrics and Gynecology	Physiology	Urology
Family Medicine*	Ophthalmology	Preventative Medicine, including Nutrition	

*ONLY applicable to medical students who enrolled in medical school on or after May 1, 1998
**ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000
***ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994

4. Did the applicant withdraw or transfer from this medical school?	[redacted]
5. What is the standard duration of the curriculum at this institution?	4 years
6. Date the applicant was enrolled in medical school?	(mm/dd/yyyy) 08/04/2011
7. Date the applicant was issued the diploma of Bachelor/Doctor of Medicine	(mm/dd/yyyy) 05/24/2015

UNUSUAL CIRCUMSTANCES DURING MEDICAL SCHOOL

Any "Yes" response below requires a signed and dated letter of explanation by school official.

8. Did this applicant ever take a leave of absence from his/her medical education?	[redacted] Yes	No
9. Was this applicant ever placed on probation?	[redacted] Yes	No
10. Was this applicant ever disciplined or placed under investigation?	[redacted] Yes	No
11. Were any limitations or special requirements imposed on this applicant because of questions of academic or disciplinary problems, or for any other reason?	[redacted] Yes	No

MEDICAL SCHOOL OFFICIAL CERTIFICATION

AFFIX MEDICAL SCHOOL SEAL

I certify that I am the President, Dean, or Registrar and hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct.

Annette Lerma — PRINTED NAME OF SCHOOL OFFICIAL

Dir., Records & Student Services — TITLE OF SCHOOL OFFICIAL

SIGNATURE OF SCHOOL OFFICIAL

July 8, 2019 — DATE

Attention Medical School: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE OR ADOPTION. Only the President, Dean, or Registrar may sign this form. If the signature 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.

MBC Use Only
Applicant Information ☑
Medical School Information
School Code: CA 012 ☑
Rev. L2 Staff Initials & Date: MM 7/16/19 ☑
☑ ☑ ☑ ☑ ☑ ☑
Unusual Circumstances ☑
School Seal ☑
Signature and Date ☑
L2

NOTE: The completed form must be mailed directly from the medical school to the Board to be acceptable.

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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: Yap	First: Joshua	Middle: P	Suffix:
Date of Birth (mm/dd/yyyy)	**Last 4 Digits of U.S. SSN or ITIN**	**Medical School of Graduation**		
[redacted]	[redacted]	Loma Linda University School of Medicine		

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

Facility Name	Montefiore Medical Center - DFSM		
Facility Address	3544 Jerome Ave Bx, NY 10467		
Specialty	Family + Preventive	**ACGME 10-digit Program #** https://apps.acgme.org/ads/Public	1203521209
Dates of Training (mm/dd/yyyy)	Start Date: 07/01/2015	End Date (or anticipated completion date): 06/30/2019	

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?	[redacted]
2. Did the applicant ever take a leave of absence or break from his/her training?	
3. Was the applicant ever terminated, dismissed or expelled?	
4. Was the applicant ever placed on probation?	
5. Was the applicant ever disciplined or placed under investigation?	
6. Were any limitations or special requirements placed upon the applicant for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?	
7. Did the program decline to renew or offer the applicant postgraduate training program contract for a following year?	

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

APPLICANT INFORMATION

LEGAL NAME: Last: Yap | First: Joshua | Middle: P | Suffix:

MBC Use Only — Applicant's Name

ATTENTION: PROGRAM DIRECTOR

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. 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 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.

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

Mary Dugan, MD

PRINTED NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR
(Signature Stamp Is Not Acceptable)

5/9/2019

DATE

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.

Notary Signature & Seal

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.

Hospital Seal

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.

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CURRENT POSTGRADUATE TRAINING ENROLLMENT

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
Yap	Joshua	P	

Date of Birth (mm/dd/yyyy)	Last 4 Digits of U.S. SSN or ITIN	Medical School of Graduation
[redacted]	[redacted]	Loma Linda University School of Medicine

PROGRAM DIRECTOR TO COMPLETE ACGME OR RCPSC TRAINING INFORMATION

Facility Name	Montefiore Medical Center - DFSM		
Facility Address	3544 Jerome Ave Bronx, NY 10467		
Specialty	Family + Preventive Med	ACGME 10-digit Program # (https://apps.acgme.org/ads/Public)	1203521209
Dates of Training (mm/dd/yyyy)	Start Date: 07/01/2015	Anticipated Completion Date: 06/30/2019	

PROGRAM DIRECTOR OFFICIAL CERTIFICATION

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.

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.

Mary Duggan, MD
PRINTED NAME OF PROGRAM DIRECTOR

SIGNATURE OF PROGRAM DIRECTOR
(Signature Stamp Is Not Acceptable)

5/9/2019
DATE

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: _____
(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 _____

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.

HOSPITAL or NOTARY SEAL

_____
SIGNATURE OF NOTARY PUBLIC

MBC Use Only
Applicant Information ☑
Verified Program Information ☑
Verified PD Staff Initials & Date
Program Director's Signature & Date ☑
Program Director's Signature ☐
Notary Signature & Seal ☐
Hospital Seal ☐

L4

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