



Osteopathic Medical Board of California

Certification of Completion of AOA or ACGME Postgraduate Training (36-month requirement)

1300 National Drive, Suite 150, Sacramento CA 95834-1991 | P (916) 928-8390 | F (916) 928-8392 | www.ombc.ca.gov

LICENSEE INFORMATION				
Full Last Name		First Name	Middle Name	Suffix
Date of Birth	Last 4 digits of SSN	License Number	License Expiration Date	
POSTGRADUATE TRAINING PROGRAM INFORMATION				
Facility Name				
Facility Address (Street)		City	State	Zip Code
Specialty		Accreditation Number & Type (AOA/ACGME)		
As of the date of this form's certification, how many months of Board approved training credit did the licensee receive? (Do not count completed months in a different program and/or the anticipated number of months to be completed.)				
Total number of months				
Training Start Date		Training End Date		
Will the licensee be enrolled in a California Board approved postgraduate training program at the time their license expires? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes" please confirm program start date: _____ Program Start Date (mm/dd/yyyy)				
NOTE: If the licensee disenrolls from the program, you are required to notify the Board by submitting a Postgraduate Training Program Status Update/Change Form				
ATTENTION: PROGRAM DIRECTOR				
The form may be signed either: 30 days prior to the resident obtaining credit for the required months of training; or after each year completed; or once the resident's training concludes at the program. Completion of this form will certify that the applicant has satisfactorily completed a period of accredited postgraduate training at this facility.				
The program director or the designated institutional official (DIO) must sign this form. If the program director or the DIO is delegating that 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.				
PROGRAM DIRECTOR OFFICIAL CERTIFICATION				
The program director or the DIO signing this form is formally certifying and documenting under penalty of perjury that the applicant received instruction appropriate for the postgraduate level and that the applicant satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to satisfactory performance.				
I hereby declare under penalty of perjury under the laws of the State of California that all of 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 completed by the applicant named on this form, and the applicant was trained in an AOA or ACGME slotted program position.				
Program Director or DIO Name (Printed)		Phone	Email	
SIGNATURE OF PROGRAM DIRECTOR OR DIO		DATE		PROGRAM SEAL (If available)
(Signature stamps are not acceptable)				

LICENSEE INFORMATION
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FACILITY INFORMATION
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TRAINING DATES
○

PROGRAM DIRECTOR
SIGNATURE & DATE
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