STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
1300 National Drive, Suite 150, Sacramento, CA 95834-1991

Application is hereby made for a Fictitious Name Permit, as required by Sections 2285 and 2415 of the California Business and Professions Code, and the following statements are submitted under oath. *(Please contact the Board at (916) 928-8390 for name availability prior to submitting your application.)*

FICTITIOUS NAME PERMIT APPLICATION FOR OSTEOPATHIC PHYSICIANS AND SURGEONS Fee - $100 ***(non-refundable)*** Please print or type. All incomplete or copied applications will be returned.	FOR OFFICE USE ONLY	
	Fee Paid: Check No.: CAS Check: / /___OK ☐ Int._____	Receipt No.: FNP No.:_

1.	Owner's complete name, practice address and practice telephone number: (List at least one Osteopathic physician's name or, in the case of a corporation, the corporate name.) If there is more than one practice location, please list all practice locations under this fictitious name permit on an attachment. Owner's Name/Corp Name:_____ Fictitious Name:_____ Practice Address:_____ Phone:_____ Email:_____

2.	The applicant is applying as: *(only check one)* ☐ Professional Medical Corporation ☐ Individual (Sole Proprietor) ☐ Partnership

3.	In the space provided below, please enter the fictitious name you wish to file. (If using initials or a non-English word, please explain the meaning of your fictitious name).

4.	**FOR PROFESSIONAL CORPORATIONS ONLY:** Corporate Name (please use the complete name):_____ Corporate No.:_____ **A copy of the approved Articles of Incorporation must be submitted with application.**

5.	If applying as an **Individual (Sole Proprietor)**, enter your Social Security Number. If applying as a **Partnership**, enter your Federal Employer Identification Number (FEIN).	SSN/FEIN #

6.

FOR CORPORATIONS ONLY: (Corporations Code Section 13401.5 (a))
A licensed physician and surgeon must own at least 51% of the outstanding shares of a professional medical corporation. The remaining 49% may be owned by: licensed podiatrists, licensed psychologists, registered nurses, licensed optometrists, licensed marriage and family therapists, licensed clinical social workers, licensed physician assistants, licensed chiropractors, licensed acupuncturists, licensed naturopathic doctors, licensed professional clinical counselors, licensed physical therapists, licensed pharmacists, licensed midwives. The number of these licensed persons cannot exceed the number of physicians and cannot exceed a combined share total of 49%. A lay (unlicensed) person cannot own any shares in a professional medical corporation in California.

ANSWER THIS QUESTION IF ALL SHAREHOLDERS ARE PHYSICIANS.
IF THERE ARE NON-PHYSICIAN SHAREHOLDERS, PROCEED TO 6B.

6a.

Name *(Attach additional sheet(s), if necessary.)*	*Shareholder?* Yes	No	Percentage of Shares	Osteopathic/Medical License No.
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

6b.

If ownership includes non-physicians, complete the following information: list the name, license number, percentage of shares and profession of all shareholders. If there are no non-physician owners, please continue to question 8.

FOR CORPORATIONS WITH NON-PHYSICIAN SHAREHOLDERS

Names of ALL shareholders (Attach additional sheet(s), if necessary)	License No.	% of Shares	Profession

7.

FOR INDIVIDUALS (SOLE PROPRIETORS), GROUPS AND PARTNERSHIPS ONLY

All owners of the applicant's organization must be listed and sign below. Where indicated, each owner must also enter the individual medical license number.

The undersigned and each of the undersigned hereby certifies under penalty of perjury the laws of the State of California that statements made on this "Fictitious Name Permit Application", and all attachments thereto, are true and correct.

Name	*Title*	*License No.*	*Date*	*Signature*
Name	*Title*	*License No.*	*Date*	*Signature*
Name	*Title*	*License No.*	*Date*	*Signature*
Name	*Title*	*License No.*	*Date*	*Signature*
Name	*Title*	*License No.*	*Date*	*Signature*
Name	*Title*	*License No.*	*Date*	*Signature*
Name	*Title*	*License No.*	*Date*	*Signature*

FOR CORPORATIONS ONLY

Complete Name of Corporation	Corporation Number

8.

I certify at least 51% of said corporation's shares are owned by a licensed physician and surgeon and as such make this declaration for and on behalf of said corporation. I have read the foregoing application and all attachments thereto and know the contacts thereof, and the same are true of my own knowledge.

I declare under penalty of perjury under the laws of the State of California that I am a licensed physician or podiatrist and have the legal authority to act on behalf of said corporation and that the information contained in this application and all attachments thereto are true and correct.

Executed at_____, California, this_day of_____,_____
(city) (month) (year)

By_____
(Type or print name) (Type or print corporate tile)

_____
Signature

Person to be contacted regarding application

Name

Telephone Number

Title

-

Email

Address (street)

City

State

Zip Code