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

OMB.29 FORM CERTIFICATION OF COMPLETION OF 36 MONTHS POSTGRADUATE TRAINING REQUIRED FOR RENEWAL

Note: Licensees must complete and submit the renewal application and training programs must submit this form to the Board for renewal. This is required documentation that demonstrates compliance with SB 806.

Effective January 1, 2022, the Legislature (SB 806) changed the licensure requirements to allow residents that have completed 12 months of postgraduate training to be eligible for a Physicians and Surgeon license with the condition that at the time of their renewal the training program submit certification of completion of 36 months of postgraduate training to the Board to be eligible for renewal. This does not apply for licensees who either already completed 36 months of postgraduate training and documented such completion to the Board or hold a full license in another state.

As a condition of license renewal, applicants not holding a full, unrestricted license in another state are required to complete 36 months of postgraduate training at the time of their renewal. This form is required for renewal of a physician and surgeon certificate (license) to verify that applicant has completed 36 months of required postgraduate training to be eligible for renewal of their Physician and Surgeon license.

This form is to be completed by the Postgraduate Training Program Director. DO NOT COMPLETE IF THE APPLICANT HAS NOT SIGNED IT. This form must be completed by <u>all</u> postgraduate training programs in which the applicant completed up to 36 months if enrolled in multiple training programs. Residents enrolled in training programs that last beyond 36 months, only need to be certified for completion of 36 months of postgraduate training.

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

_____

Applicant Signature

POSTGRADUATE TRAINING PROGRAM INFORMATION

Facility Name			
Facility Address (street)	City	State	Zip Code

Specialty	Accreditation (AOA or ACGME) and Accreditation Number

ROTATIONS

Please list the type of rotation and length below or attach a printout or list of rotations completed by resident. Please list rotations completed below or attach printout. If training was not rotating, indicate type of straight training performed.

Rotation	Length of Rotation

ATTENTION: POSTGRADUATE TRAINING PROGRAM DIRECTOR

Do not sign and date this form prior to the completion of required 36 months postgraduate training. Completion of this form will certify that the applicant has satisfactorily completed 36 months of accredited postgraduate training at this facility and that the applicant has acquired the skills and qualifications necessary to safely assume the unrestricted practice of medicine in this state. The purpose of this form is to certify completion of 36 months of postgraduate training.

If a resident is enrolled in a training program beyond 36 months, the certification should only be for the completion of 36 months, not the yet to be completed portion of the training. Only the program director shall 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 photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

POSTGRADUATE TRAINING PROGRAM DIRECTOR CERTIFICATION

I CERTIFY THAT _____COMPLETED
(postgraduate graduate's name)

this training that consists of _____months of clinical instruction that is approved by the American Osteopathic Association (AOA) or Accreditation Council for Graduate Medical Education (ACGME)

Dates of Training:

Start Date (MM/DD/YYYY) **End Date (MM/DD/YYYY)**

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 skills and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

POSTGRADUATE TRAINING PROGRAM DIRECTOR'S ATTESTATION

***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.**

_____

Print Name of Program Director

Program Seal

_____

Address

_____

Address

_____

Phone

_____

Email

Signature of Program Director:

_____ _____

(Sign Full Name, Signature Stamps not Accepted) ***Date***

This form cannot be accepted without the hospital seal. If the program does not have a seal, the Program Director shall sign in the presence of a notary public and have notary place the notary seal below.

The completed form must be mailed directly from the training program to the Board to be accepted.

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, _____
(Print Program Director's Name)

the person who appeared before me proved to me on the basis of satisfactory evidence to be the person who appeared before me.

NOTARY SEAL

_____

(Signature of Notary Public)