



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



APPLICATION FOR OSTEOPATHIC POSTGRADUATE TRAINING LICENSE INSTRUCTIONS

This application is only for postgraduate resident trainees who are applying for a Postgraduate Training License. To be eligible for a Postgraduate Training License, an applicant must be enrolled in a California Postgraduate residency training program. A Postgraduate Training License (PTL) must be obtained within 180 days after enrollment in an American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA) or Accreditation Council for Graduate Medical Education (ACGME) accredited postgraduate training program in California. The PTL will be valid until 90 days after a trainee has successfully completed 36 months of postgraduate training at which point a full and unrestricted physician and surgeon certificate must be obtained in order to continue providing clinical services in California.

MINIMUM REQUIREMENTS

- Applicants must submit a complete application for Postgraduate Training License OMB.22 form that is signed and notarized. Applicants must apply manually by downloading the forms from the Board's website or apply online setting up a "Breeze" account. Online applicants must download and submit the notary form with their online application summary. No digital signatures or faxes are accepted.
- Those applying manually must pay by check or money order, those applying online must pay by credit card. The PTL fee is a \$491 non-refundable application and processing fee plus the non-refundable \$49 for fingerprint processing fee for a total of \$540.
- To be eligible for a PTL, applicants must have their programs submit proof that the applicant is enrolled in an AOA or ACGME accredited postgraduate training program in California using Form OMB 23, which is downloadable from the Board's website.
- Applicants who complete their postgraduate training in multiple programs must complete at least 2 years at one program of the 36 months. They are required to obtain a PTL for any portion of the 36 months residency located in California.
- Applicants who are enrolled in a California residency program in their third year must apply and obtain a Postgraduate Training License to participate in their residency. The fees are the same regardless of the time enrolled in the training program and they are non-refundable. There are no guest residency licenses. All residency trainees must have a Postgraduate Training License to practice in their residency training programs.
- Applicants must have received all of the osteopathic medical school education from and graduated from a U.S. osteopathic medical school accredited by the AOA's Commission on Osteopathic College Accreditation (COCA) and document on the OMB.22 application form.
- To meet the examination requirements, the applicant must have taken and passed the National Board of Osteopathic Medical Examiners, Inc. (NBOME) Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-US) levels 1, 2 Cognitive Evaluation (CE) and 2 Performance Evaluation (PE)—applicant must request that NBOME send exam scores directly to OMBC.

- Before the OMBC can issue a PTL, fingerprint clearances must be received from the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI).
- Disclosure of a United States Social Security Number (SSN) or an Individual Taxpayer Identification Number (ITIN) is mandatory prior to the issuance of a PTL. Section 30 of the Business and Professions Code authorizes collection of an SSN or ITIN. Section 31 (e) allows the State Board of Equalization and the Franchise Tax Board to share taxpayer information with the Board.

GENERAL INFORMATION

There are two ways to apply for a PTL:

Manually. Applicants must download all of the PTL forms, complete them and submit them by mail with a check or money order; or

Online. Applicants choosing to submit their application online are required to create a “Breeze” account and input application details online and pay online with a credit card. Online applicants are still required to download other required forms including the notary form, which must be notarized and submitted to the Board by mail along with the online application summary. The application is not complete without the notary form and the online application summary. The only online form is the application form OMB.22. The other required forms are only available from the Board’s website. The program enrollment form OMB.23 is downloadable and must be completed and notarized by the residency training program, not the applicant.

Fees. Applicants must pay a non-refundable application and processing fee of \$540 which includes \$491 plus a \$49 fingerprint process fee to OMBC at the time they submit their application. These fees are non-refundable. The fee is the same regardless of the length of time enrolled in a California residency program.

Notary Cam. Notary Cam is a company that provides an online notary service that is valid in California and can be used on the Board’s application forms. The Board does not mandate the use of this service. The Board is providing this information as a convenience to applicants and training programs. Applicants may obtain further information regarding this online notary services at: <https://www.notarycam.com/>

Application Timeline. The application timeline begins with receipt of a completed application and payment of application fee and fingerprint fee. The full process can take up to 6 months to complete.

- Application processing is dependent on receipt of transcripts from school(s), copy of diploma, COMLEX scores, and fingerprint clearance. Please allow ample time to ensure OMBC receives your Postgraduate Training License Enrollment form OMB.23 within 180 days of enrollment in a training program. Failure to obtain a PTL within the 180 days of enrollment in training program will result in you having to cease all practice of medicine within the training program.
- OMBC will only discuss your application status with you and those specific persons whom you designate.
- Signatures on required forms must be wet signatures; digital, fax or other formats are not acceptable.

- Your application is considered complete once the application and processing fee, all required forms, documentation, DOJ and FBI fingerprint clearance have been received and approved by OMBC. Forms submitted that are not deemed by the Board to be complete will be returned to applicants.
- Temporary licenses are not available.

Contact Information Changes

Applicants are responsible to notify the Board, in writing of any address, e-mail, or name changes made during the application process. Failure to do so may cause delay in being issued a PTL.

Military Spouse/ Legal Partner Expedited Processing

To expedite the licensure process, persons honorably discharged from the military must submit a copy of their DD214 or active military must submit copy of their military orders. In addition, those seeking expedited processing due to marriage/legal partnership must submit a copy of their spouse/domestic partner's military orders showing they are stationed at a military installation in California.

Grounds for Denial: Each applicant's credentials for licensure in California are reviewed on an individual basis. The Board has the authority to deny licensure based upon an applicant's act of dishonesty, unprofessional conduct, conviction of a crime, discipline of another state license, or inability to practice medicine safely.

APPLICATION CHECKLIST

FORMS

Application for Postgraduate Training License OMB.22. Please complete and submit directly to OMBC. This form must be signed and notarized. The notary form is downloadable from the Board's website.

Postgraduate Training License Enrollment Form OMB.23. You must send this form to your postgraduate training program and request your training program complete and submit this form directly to the Board.

- ✓ Proof of the applicant's enrollment in an AOA or ACGME accredited postgraduate training program is required.
- ✓ Applicants must download the form and submit the form to their postgraduate training Program Director. The postgraduate training Program Director must complete the form with all of the required information and responses on the form, sign, date and affix training program seal. If program does not have a seal, then program director must sign in the presence of a notary and notary seal must be affixed to the form.
- ✓ Applicant must send one of the three required current photos with this form to their postgraduate training program.
- ✓ Any letters of explanation must be on program letterhead and signed by the program director and mailed directly to the Osteopathic Medical Board of California.
- ✓ The form must be signed by the training program director and mailed directly from the training program to the Osteopathic Medical Board of California, 1300 National Drive, Suite 150, Sacramento, CA 95834. Forms not mailed by training program will not be accepted. Faxed copies or emails will not be accepted.

Postgraduate Training Certification OMB.25 (If applicable). This form is required only if the applicant has completed 1 or 2 years prior postgraduate training, otherwise it is optional.

- ✓ If applicant has no prior postgraduate training, this form is not required for the PTL application.
- ✓ For applicants that participate in more than one postgraduate training program, this form is required to be completed by each postgraduate training program the applicant has completed some period of postgraduate training.
- ✓ This the same form that is required to be completed by the postgraduate training program at the end of the 36 months.

Postgraduate Training Program Update Form OMB.24. (when applicable). The Training Program Director must submit this form to OMBC within 30 days of any change in status of a resident with a PTL.

- ✓ If a trainee moves or transfers to another program, is terminated, resigns, or takes a leave of absence, the training program director must submit to OMBC a Training Update form OMB.24 directly to OMBC.

Verification of Licensure Form OMB.4 (if applicable).

- ✓ This form must be submitted by you to every state in which you are or have been fully licensed (excludes temporary licenses) or otherwise registered to practice as an osteopathic physician and surgeon or other health care provider.
- ✓ Please make additional copies as needed.
- ✓ Each licensing agency must then forward the completed form with their agency seal, directly to the Osteopathic Medical Board of California (OMBC). Fax copies are not acceptable.

FEE

Applicants (or postgraduate training programs) must mail a check for \$540 which includes \$491 application and processing fee and \$49 fingerprint processing fee.

- ✓ Make check or money order payable to the Osteopathic Medical Board of California or OMBC.
- ✓ Application and fingerprint processing fees are nonrefundable.
- ✓ Online applicants must pay by credit card.

PHOTOGRAPHS

- ✓ Applicants are required to submit three (3) recent 2"X 2" (approximate size) passport quality photographs of your head and shoulders only. All three photographs must be identical. No digital or faxed photos or photo copied or other formats are accepted.
- ✓ One photograph must be affixed to your application form OMB.22, and
- ✓ One photo must be affixed to your postgraduate training Enrollment Certification form OMB.23, and
- ✓ One photo must be included that is not affixed to any document that will be used for your official license file.

WRITTEN EXAMINATION VERIFICATION

- ✓ Applicants must contact the National Board of Osteopathic Medical Examiners, Inc. (NBOME) to request a certified copy of your COMLEX-US levels 1, 2CE, 2 PE. scores.
- ✓ Your certified exam COMLEX-US exam scores must be sent directly by NBOME to the Osteopathic Medical Board of California (OMBC). Fax copies are not accepted. Copies of exam scores submitted by applicant are not accepted. Contact NBOME at www.nbome.org

CERTIFIED OFFICIAL OSTEOPATHIC MEDICAL SCHOOL TRANSCRIPT

- ✓ Applicants must contact their osteopathic medical school and request a certified copy of your transcript.
- ✓ The certified official transcript must be sent directly by your school to the Osteopathic Medical Board of California (OMBC). A copy issued to a student is not accepted.

OSTEOPATHIC MEDICAL SCHOOL DIPLOMA

- ✓ Applicants must send a copy of their medical school diplomas with their application.
- ✓ If you ordered your Written Exam Verification (NBOME scores), Transcript, and/or Diploma from Federal Credential Verification Services (FCVS), you must provide the information to us on a separate piece of paper when you submit your application. Failure to do so will result in delayed processing of your application.

FINGERPRINT PROCEDURES

Criminal Record Check clearance from both California Department of Justice and the Federal Bureau of Investigation must be received by OMBC prior to the issuance of a PTL.

Live Scan

Applicants residing in California must use the Live Scan process. If a Live Scan site is not available near you, please contact the OMBC for further instructions.

Live Scan process:

- ✓ Complete the OMBC's "Request for License Scan Services" fill and print form (in triplicate) downloadable from the OMBC website.
- ✓ Take the completed form (in triplicate) to a Live Scan site.
- ✓ Submit the second copy of the form to the Board with your license application.
- ✓ Keep the third copy for your records.

To locate a Live Scan site near you, visit <http://ag.ca.gov/fingerprints/publications/contact.php> or contact OMBC at (916)928-8390. Hours of operation and rolling fees vary at Live Scan sites, so please contact the Live Scan site directly for information.

OR

Fingerprint Cards

Applicants residing outside California must use the manual fingerprint card process. Please contact the OMBC office at (916) 928- 8390 OR e-mail osteopathic@dca.ca.gov to request and obtain fingerprint cards. Please provide your mailing address where you wish the fingerprint cards to be mailed. **Results from the manual process can take up to 16 weeks.**

Manual Fingerprint Process:

- ✓ Contact the OMBC to obtain two fingerprint cards.
- ✓ Complete all applicable areas on both cards (refer to instructions sheet included with the cards).
- ✓ Take the completed cards to a local law enforcement office or a verifiable finger printing service and have your fingerprints rolled.
- ✓ Submit both fingerprint cards to the OMBC with your license application **DO NOT FOLD CARDS.**
- ✓ OMBC will not be able to process your application without both completed fingerprint cards.

PTL will not be issued until fingerprint clearances from both DOJ and FBI are received by OMBC.



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



For Official Use:
 Entity No. _____ File No. _____ Amount Paid: _____ Initials _____

APPLICATION FOR OSTEOPATHIC POSTGRADUATE TRAINING LICENSE

Please read all instructions prior to completing this application. All questions must be answered. If something is not applicable, write N/A/, do not leave it blank. In addition to this form, other essential application requirements must be completed. FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

1. NAME: Last		First:	Middle:	
OTHER NAMES USED IF ANY:		Social Security No. or Individual Taxpayer ID No.		
3. DATE OF BIRTH	4. PLACE OF BIRTH		5. Gender: Male Female	
6. Confidential Mailing Address (For Board use only) Street		City	State	Zip Code
Address of Record (Public Address) Street		City	State	Zip Code

7. CONTACT INFORMATION FOR APPLICATION PROCESS:

Daytime Phone Number	Email		
8. PRE-OSTEOPATHIC COLLEGES			
Address (street, city, state, zip code)		DATES OF ATTENDANCE	

TITLE OF DEGREE AWARDED		ISSUANCE DATE OF DEGREE AWARDED
9. OSTEOPATHIC COLLEGES	Address (street, city, state, zip code)	DATES OF ATTENDANCE
		Start: End:
		Start: End:
		Start: End:

Title of Degree Awarded	ISSUANCE DATE OF DEGREE AWARDED

10. POSTGRADUATE TRAINING IN CALIFORNIA YOU ARE CURRENTLY OR WILL BE ENROLLED

INTERNSHIP (AOA) Hospital Name	Address (street, city, state, zip code)	Specialty	DATES OF ATTENDANCE

RESIDENCY/FELLOWSHIP Hospital Name	Address (street, city, state, zip code)	Specialty	DATES OF ATTENDANCE

11. PRIOR POSTGRADUATE TRAINING YOU HAVE ATTENDED OR COMPLETED (internship, residency, fellowship)

Hospital Name	Address (street, city, state, zip code)	Specialty	DATES OF ATTENDANCE

12. BOARD CERTIFIED: Yes No NAME OF CERTIFYING BOARD	DATE COMPLETED
13. LIST ALL WRITTEN EXAMINATIONS PASSED	DATE COMPLETED

14. LIST ALL STATES IN WHICH YOU ARE CURRENTLY LICENSED OR HAVE EVER BEEN LICENSED TO PRACTICE OSTEOPATHIC MEDICINE. *written examination, National Boards, etc.

State	Date licensed	*How Licensed	License Number

15. Are you serving, or have you previously served in the military? Yes No

16. Are you married to, or in a domestic partnership or other legal union, with an active duty member of the U.S. military assigned to duty in California? Yes No

For any “Yes” answers to the following questions requires a written explanation that is signed and dated and identifies each question being answered. Submit written explanation as a separate attachment with application.

17. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training program? If yes, attach explanation. Yes No

18. Has a claim or action for damages ever been filed against you in the course of the practice of medicine or any other healing art which resulted in a malpractice settlement, judgment or arbitration award of over \$30,000.00? Yes No

19. Has there ever been any peer group or professional association inquiry or action involving your practice or relationship with patients alleging unprofessional conduct, wrongdoing or negligence? Yes No

20. Have you ever withdrawn an application from any hospital, public entity or licensing agency? Yes No

If Yes, When? (please explain on separate attachment or where space provided)

21. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed for medical disciplinary case, or resigned from a medical staff in lieu of disciplinary or administrative action, or is any such action pending? Yes No

22. Have you ever had a medical or any healing arts license restricted, suspended, revoked, surrendered, disciplined or denied in any state? Yes No

23. Have you ever been denied permission to practice medicine or any healing arts in any state? Yes No

24. Do you have any condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety, including but not limited to, any of the following? Yes No

IF YES, PLEASE CHECK THE APPROPRIATE BOX(ES) BELOW:

- A condition which required admission to an inpatient psychiatric treatment facility
- Alcohol or chemical substance dependency or addition
- Emotional, mental or behavioral disorder
- Other (explain)

If necessary, add further explanation for the above questions below or include additional information in a separate attachment. Please include each question number with each answer.

Explanation questions 17- 24

ATTENTION: This application is not complete, you must download the application, sign the application in the presence of a notary public and submit a hard copy of the application that is signed and notarized and mail to Osteopathic Medical Board of California (OMBC). Faxes will not be accepted.

Paste a recent 2 X 2
(approximate size)
Photo must be of your
head and shoulder Area only
(Title 16 CCR Section 1613)

NOTICE OF COLLECTION OF PERSONAL INFORMATION

Agency requesting information: Osteopathic Medical Board of California, 1300 National Drive, Suite 150, Sacramento, CA 95834, (916) 928-8390. The information requested herein is mandatory, unless otherwise indicated, and is maintained by the Osteopathic Medical Board of California (Board), 1300 National Drive, Suite 150, Sacramento, California 95834, Executive Officer, (916) 928-8390, in accordance with Business & Professions Code section 3600 et seq. Disclosure of your individual taxpayer identification number or social security number is mandatory and collection is authorized by Section 30 of the Business & Professions Code. Failure to provide all or any part of the requested mandatory information will result in the rejection of your application as incomplete. Except for the individual taxpayer identification number or social security number, the information requested will be used to identify and evaluate applicants for licensure, issue and renew licenses, and enforce licensing standards set by statutes and regulations. Your individual taxpayer identification number or social security number will be used exclusively for tax enforcement purposes, compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or verification of licensure or examination status by a licensing or examination board where licensing is reciprocal with the requesting state. It will not be deemed to be a public record and will not be disclosed to the public. If you fail to disclose your individual taxpayer identification number or social security number you will be reported to the Franchise Tax Board (FTB), which may assess a \$100 penalty against you. Upon request, the Board will provide the FTB with your name, address(es) of record, individual taxpayer identification number or social security number, type of license and status, and effective date and expiration date of your license or renewal. You have the right to review your personal information maintained by the agency unless the records are exempt from disclosure. Please note that certain information you provide may be disclosed under some circumstances, such as: in response to a Public Records Act (PRA) request (beginning with Government Code section 6250), to another government agency as required by state or federal law, or in response to a court or administrative order, subpoena, or search warrant.

APPLICANT CERTIFICATION AND DECLARATION

I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND CORRECT. Further, I further hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past or present), or business and professional associates (past or present, and future), and all government agencies (local, state, federal) to release to the Osteopathic Medical Board of California 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 the 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 UNDERSTAND THAT ANY OMISSION, FALSIFICATION, OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

(Signature of applicant—signed in presence of notary public)

Date

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 to be the person who
appeared before me.
(Print Applicant’s Legal Name)

(Signature of Notary Public)

NOTARY SEAL

(Address)

My Commission expires _____



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



ONLINE APPLICATION NOTARY FORM

Paste a recent 2" X 2"
(approximate size) photo here.
Photo must be of your head
and shoulder area only.
CCR 1613.

APPLICANT CERTIFICATION AND DECLARATION

I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND CORRECT. Further, I further hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past or present), or business and professional associates (past or present, and future), and all government agencies (local, state, federal) to release to the Osteopathic Medical Board of California 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 the 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 UNDERSTAND THAT ANY OMISSION, FALSIFICATION, OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

(Signature of Applicant—signed in presence of notary public) _____
Date

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 to be the
(print applicant's legal name)
Person who appeared before me.

NOTARY SEAL

(signature of notary public)

(Address)

My Commission expires _____



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
(Signature Stamp is not Acceptable)

Date

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.



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 STATUS UPDATE/CHANGE FORM

TRAINEE INFORMATION

Legal Name: Last	First	Middle	Suffix

PROGRAM DIRECTOR TO COMPLETE AOA OR ACGME TRAINING INFORMATION

Training Program Name: _____

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

Status Update/Change	Continued Enrollment (Y/N)	No Longer Enrolled Effective: (mm/dd/yyyy)
	Yes No	

- Did the trainee resign from the program? If Yes: Date: __/__/____ Yes No
- Did the trainee ever take a leave of absence or break from his/her training? Yes No
 Dates of leave: Start date: __/__/____ through End date: __/__/____
- Was the trainee ever terminated, dismissed or expelled? **A "Yes" response requires a written explanation that is signed and dated.** Effective Date: __/__/____ Yes No
- Did the program decline to renew or offer the trainee a postgraduate training program contract for the following year? **A "Yes" response requires a written explanation signed and dated.** Yes No
- Did the trainee transfer to another program? Yes No
 If Yes: Location: _____ Date: __/__/____
- Is there another reason for the status update or change? **A "Yes" response requires a written explanation signed and dated.** Yes No

PROGRAM DIRECTOR SIGNATURE

SIGNATURE OF PROGRAM DIRECTOR : _____
 (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)

PROGRAM OR NOTARY SEAL

 (Signature of Notary Public)

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



REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A0065

ORI (Code assigned by DOJ)

Authorized Applicant Type

Osteopathic Physician&Surgeon

Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

OMB

Agency Authorized to Receive Criminal Record Information

05119

Mail Code (five-digit code assigned by DOJ)

1300 National Drive, Suite 150

Street Address or P.O. Box

Sabrina Rowell

Contact Name (mandatory for all school submissions)

Sacramento

City

CA 95834

State ZIP Code

(916) 999-3425

Contact Telephone Number

Applicant Information:

Last Name

First Name

Middle Initial

Suffix

Other Name

(AKA or Alias) Last

First

Suffix

Date of Birth

Sex Male Female

Driver's License Number

Height

Weight

Eye Color

Hair Color

Billing

Number 100124

(Agency Billing Number)

Place of Birth (State or Country)

Social Security Number

Misc.

Number

(Other Identification Number)

Home

Address Street Address or P.O. Box

City

State

ZIP Code

Your Number:

OCA Number (Agency Identifying Number)

Level of Service:



DOJ



FBI

If re-submission, list original ATI number:

(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

Employer Name

Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City

State

ZIP Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

LSID

ATI Number

Amount Collected/Billed



REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A0065

ORI (Code assigned by DOJ)

Authorized Applicant Type

Osteopathic Physician&Surgeon

Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

OMB

Agency Authorized to Receive Criminal Record Information

1300 National Drive, Suite 150

Street Address or P.O. Box

Sacramento

City

CA

State

95834

ZIP Code

05119

Mail Code (five-digit code assigned by DOJ)

Sabrina Rowell

Contact Name (mandatory for all school submissions)

(916) 999-3425

Contact Telephone Number

Applicant Information:

Last Name

First Name

Middle Initial

Suffix

Other Name

(AKA or Alias) Last

First

Suffix

Date of Birth

Sex

Male

Female

Driver's License Number

Height

Weight

Eye Color

Hair Color

Billing

Number 100124

(Agency Billing Number)

Misc.

Number

(Other Identification Number)

Place of Birth (State or Country)

Social Security Number

Home

Address Street Address or P.O. Box

City

State

ZIP Code

Your Number:

OCA Number (Agency Identifying Number)

Level of Service:

DOJ

FBI

If re-submission, list original ATI number:

(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

Employer Name

Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City

State

ZIP Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

LSID

ATI Number

Amount Collected/Billed



REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A0065

ORI (Code assigned by DOJ)

Authorized Applicant Type

Osteopathic Physician&Surgeon

Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

OMB

05119

Agency Authorized to Receive Criminal Record Information

Mail Code (five-digit code assigned by DOJ)

1300 National Drive, Suite 150

Sabrina Rowell

Street Address or P.O. Box

Contact Name (mandatory for all school submissions)

Sacramento

CA 95834

(916) 999-3425

City

State ZIP Code

Contact Telephone Number

Applicant Information:

Last Name

First Name

Middle Initial

Suffix

Other Name

(AKA or Alias) Last

First

Suffix

Date of Birth

Sex Male Female

Driver's License Number

Height

Weight

Eye Color

Hair Color

Billing

Number 100124

(Agency Billing Number)

Misc.

Number

(Other Identification Number)

Place of Birth (State or Country)

Social Security Number

Home

Address Street Address or P.O. Box

City

State

ZIP Code

Your Number:

OCA Number (Agency Identifying Number)

Level of Service:



DOJ



FBI

If re-submission, list original ATI number:

(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

Employer Name

Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City

State

ZIP Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

LSID

ATI Number

Amount Collected/Billed

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
NOTIFICATION OF NAME CHANGE

The California Department of Consumer Affairs may recognize a name change by an applicant or licensee if that name is now his or her legal name for all purposes and if the change is not made for fraudulent purposes and is not misleading to the public.

Important Submission Information: Submission of this form will serve as a notification of name change to all California Boards and Bureaus operating on the BreEZe system. For a complete listing of which licensing Boards and Bureaus this name change will affect, please see the back of this form. Incomplete packets will not be accepted or returned.

SECTION A: NAME CHANGE INFORMATION		
Former First Name	Former Middle Name	Former Last Name
New First Name	New Middle Name	New Last Name
Last Four of SSN#	License #	Date of Birth (MM/DD/YYYY)

SECTION B: DOCUMENTATION REQUIREMENTS AND OPTIONS
You must submit photocopies or electronic copies of the following <u>two</u> required documents: 1. A current government issued photographic identification (e.g., driver license, alien registration, passport, etc.) AND 2. One of the following additional legal documents as proof of name change. Check one and attach a copy of the document.
<input type="checkbox"/> Certified Court Order <input type="checkbox"/> Marriage Certificate <input type="checkbox"/> Dissolution of Marriage (Divorce)

SECTION C: PERSONAL ATTESTATION
I declare under penalty of perjury under the laws of the State of California that the information given above is true and correct and that I am the person who was issued the original California license by the Department of Consumer Affairs or submitted an application.
I hereby certify that the name change is not made for fraudulent purposes.
X _____

Mail to:
Osteopathic Medical Board of California
1300 National Drive, Suite 150
Sacramento, CA 95834-1991

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
NOTIFICATION OF NAME CHANGE

Boards and Bureaus this Name Change will affect:

Submission of this form will serve as a notification of name change to all California Boards and Bureaus operating on the BreZE system. Below is a list of the licensing Boards and Bureaus currently on the BreZE system. If you hold a license with a Board or Bureau which is not currently on the BreZE system, you must submit a separate name change form directly to that program.

- **California Board of Barbering and Cosmetology**
- **California Board of Behavioral Sciences**
- **Dental Board of California**
- **Dental Hygiene Committee of California**
- **Medical Board of California**
- **Naturopathic Medicine Committee**
- **Board of Occupational Therapy**
- **California Board of Optometry**
- **Osteopathic Medical Board of California**
- **Physical Therapy Board**
- **Physician Assistant Board**
- **Board of Podiatric Medicine**
- **California Board of Psychology**
- **Board of Registered Nursing**
- **Respiratory Care Board**
- **Bureau of Security and Investigative Services**
- **Veterinary Medical Board**
- **Board of Vocational Nursing and Psychiatric Technicians**

Check this box if you hold a license with two or more of these programs

Mail to:
Osteopathic Medical Board of California
1300 National Drive, Suite 150
Sacramento, CA 95834-1991



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



Request to Order License Endorsement/Verification

Each endorsement (verification) ordered requires a \$25.00 fee

Licensee: Please Complete the Following:

I am requesting that the Osteopathic Medical Board of California prepare and mail a license endorsement/verification for:

Name: _____

License #: 20A_____

Mail endorsement/verification to:

Signature: _____

Licensee: Mail This Completed Form and Check for \$25.00 to:

Osteopathic Medical Board of California
1300 National Drive, Suite 150
Sacramento, CA 95834-1991

Cashiering: Transaction Code 8030



Postgraduate Training License Request to Order Duplicate License Certificate

There is a \$25.00 fee for the certificate.

- Please provide:

Name: _____

License #: PTL_____

- Place the appropriate check marks below:

Pocket Certificate ()

Lost

Stolen

- Explanation as to why you are requesting a duplicate certificate:

- Mail completed form and check or money order to:

Osteopathic Medical Board of California
1300 National Drive, Suite 150
Sacramento, CA 95834-1991

Cashiering: Transaction Code 8001