State of California Department of Consumer Affairs

**OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA**
**1300 National Drive, SUITE 150**
**SACRAMENTO, CA 95834-1991**
**TELEPHONE: (916) 928-8390**
**FAX (916) 928-8392**

# CHECK SHEET- GENERAL INFORMATION

Please use the following information checklist to be sure that your application is complete and accurate before submitting it. All items listed on the front and back that are applicable to you must be submitted in order for your qualifications for licensure to be assessed.

## FORMS

☐ Form OMB.1 Application for Osteopathic Physician's and Surgeon's Certificate *(must be notarized).*

☐ Form OMB.2 Certification of Completion of ACGME Postgraduate Training or AOA Rotating Internship *must be sent by you to your training program. The training program must complete the form* ***after you have completed your first year postgraduate training. The certification must be returned to the Board directly from the program and will not be accepted if submitted by the applicant. Fax copy is not acceptable.***

☐ Form OMB.3 Verification of Licensure *must be submitted by you to every state in which you are or have been licensed or otherwise registered to practice as an osteopathic physician and surgeon or other health provider. Please make additional copies of this form 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.*

## PHOTOGRAPH

☐ Three (3) recent 2" x 2" (approximate size) passport quality photograph of your head and shoulders only. **All three photographs must be identical.** *One affixed to your application form OMB.1, second one affixed to your postgraduate training certification form OMB.2 and the third photo loosely submitted with your application package.*

## WRITTEN EXAMINATION VERIFICATION

☐ National Board of Osteopathic Medical Examiners, Inc. NBOME/COMLEX levels I – III Scores
Contact the National Board of Osteopathic Medical Examiners Inc. at 8765 West Higgins, Suite 200, Chicago, IL 60631; telephone (773) 714-0622 to request **certified** copy of your NBOME/COMLEX scores. *Your* ***certified*** *NBOME/COMLEX scores must be sent directly by NBOME to the OMBC. Fax copies are not acceptable. You must contact all other examination administrators to have* ***certified*** *scores sent directly to the OMBC.*

**Or**

☐ NBOME Parts I and II and FLEX Component II with a minimum score of 75% substituted for Part III of the NBOME (Note: FLEX - not administered after 12/31/1993)

**Or**

☐ A State Written Examination shall be considered on a case-by-case basis. The applicant must hold a current, unrestricted license to practice osteopathic medicine in that State.

**Or**

☐ The Comprehensive Osteopathic Medical Variable Purpose Examination (COMVEX) is acceptable in lieu of a State Written Examination (above). ***NOTE: SPEX (Special Purpose Examination) is no longer accepted)***

**CERTIFIED OFFICIAL OSTEOPATHIC COLLEGE TRANSCRIPT**

☐ Contact your osteopathic medical school to request a **certified** copy of your transcript. The certified, official osteopathic college transcript must be sent directly by your school to the OMBC. Copy issued to student will not be acceptable.

**OSTEOPATHIC COLLEGE DIPLOMA**

☐ A copy of your osteopathic college diploma must be submitted with your application.

**INTERNSHIP CERTIFICATE**

☐ Applicants who completed their first-year postgraduate training prior to 1990 must submit a copy of their internship certificate with their application.

**FINGERPRINT PROCEDURES**

Before the OMBC issues a license, clearances must be received from the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI).

**1. 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 Board office for further instructions.

Live Scan Process
1. Complete the OMBC's "Request for Live Scan Services" fill and print form (in triplicate).
2. Take the completed form (in triplicate) to a Live Scan site.
3. Submit the **second copy** of the form with your license application.

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

**2. Fingerprint Cards**

If you reside outside California, you **must** use the manual fingerprint card process. Please contact the OMBC office at (916) 928-8390 or e-mail us at osteopathic@dca.ca.gov to obtain fingerprint cards. Results from the manual card process can take up to 16 weeks.

Manual Fingerprint Process
1. Contact the OMBC to obtain two fingerprint cards.
2. Complete all applicable areas on both cards (refer to instruction sheet included with the cards).
3. Take the completed cards to a local law enforcement office and have your fingerprints rolled.
4. 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.

***License will not be issued until fingerprint clearances from both the DOJ and FBI are received.***

**FEES** *(One check for $251)*

☐ Application Processing Fee: $200

☐ Fingerprint Processing Fee: $51

Make check or money order payable to the Osteopathic Medical Board of California. Application and fingerprint processing fees are nonrefundable.

## REQUIREMENT FOR LICENSURE

Do not submit your application until you have completed your first year postgraduate training and you have successfully completed all three levels of the NBOME/COMLEX.

The Board determines that no disciplinary action has been taken against the applicant by any medical licensing authority; the applicant has not been subject to adverse judgments or settlements resulting from the practice of medicine, which the Board determines constitutes evidence of a pattern of negligence or incompetence.

Temporary license is **not** available.

***The review and approval process will take up to six months. Please do not contact the OMBC regarding the status of your application for at least 30 days after submitting your application.***

## GENERAL INFORMATION

Your application is considered complete once all required forms, documentation, DOJ and FBI fingerprint clearances and appropriate fees have been received and approved. You will be notified of the status of your application, including any deficiencies, generally within 30 days from the date your application is filed. Once your application has been approved, you will be notified as to the amount of the license fee you will need to remit. License fee is $400 for two years, renewable every other year in your birth month (even birth month. i.e., February, April, June, etc., renew every even year, odd birth month i.e., January, March, May, etc., renew every odd year). Your initial license fee will be prorated based on your birth month.

It is your responsibility to notify OMBC, in writing, of any address or name changes.

If your application is denied by the Osteopathic Medical Board of California, you will be notified in writing the reason(s) for denial and the appeal process.

Incomplete applications are kept on file for a period of one year. If the application process is not completed within that period, your application will be destroyed.

Department of Consumer Affairs
**Osteopathic Medical Board of California**
1300 National Drive, Suite 150
Sacramento, CA 95834
(916) 928-8390 Fax (916) 928-8392
www.dca.ca.gov/osteopathic

# APPLICATION FOR OSTEOPATHIC PHYSICIAN'S AND SURGEON'S CERTIFICATE

Please read all instructions prior to completing this application. All questions on this application must be answered. 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 A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE.

*Please type or print legibly. If space provided is insufficient, attach additional sheets.*

| 1. NAME: Last: | First: | Middle: |
|---|---|---|
| OTHER NAMES USED if any: | | 2. SOCIAL SECURITY NO: |
| 3. DATE OF BIRTH: | 4. PLACE OF BIRTH: | 5. SEX: Male ☐ Female ☐ |
| 6. ADDRESS: | | |
| MAILING ADDRESS if different: | | |
| 7. CONTACT INFORMATION FOR APPLICATION PROCESS: Daytime Phone Number: E-Mail address: | | 8. Are you a US citizen? Yes ☐ No ☐ |

| 9. PRE-OSTEOPATHIC COLLEGE(S) | ADDRESS | DATES OF ATTENDANCE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| 10. OSTEOPATHIC COLLEGE(S) | ADDRESS | DATES OF ATTENDANCE: |
| | | DATE OF DEGREE: |

| 11. POSTGRADUATE TRAINING INTERNSHIP (AOA) | Hospital Name | Address | Type of Service | Dates of Attendance |
|---|---|---|---|---|
| RESIDENCY/FELLOWSHIP: | | | Dates of Service | |

12. BOARD CERTIFIED: Yes ☐ No ☐ DATE CERTIFIED: NAME OF CERTIFYING BOARD:

13. LIST ALL WRITTEN EXAMINATIONS TAKEN e.g. NBOME, State Written Boards, USMLE, FLEX etc.

| STATE WHICH EXAMINATIONS AND WHERE TAKEN | DATE COMPLETED |
|---|---|
| | |
| | |
| | |
| | |

14. LIST ALL STATES IN WHICH YOU ARE NOW LICENSED OR HAVE EVER BEEN LICENSED TO PRACTICE OSTEOPATHIC MEDICINE

*Written examination, reciprocity, National Boards, etc.

| STATE | DATE LICENSED | * HOW LICENSED | LICENSE NUMBER |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

15. Have you ever applied for but did not take the California Osteopathic Medical Board Examination? If Yes, when? Yes ☐ No ☐

16. Have you ever taken the California Osteopathic Medical Board Examination? If Yes, when? Yes ☐ No ☐

17. Have you ever withdrawn from, or been suspended, dismissed or expelled from a medical school or postgraduate training? 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? If Yes, When? Yes ☐ No ☐

21. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed for medical disciplinary cause, 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 art license restricted, suspended, revoked, disciplined or denied in any state? Yes ☐ No ☐

23. Have you ever been denied permission to practice medicine or any healing art 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 addiction
- ☐ Emotional, mental or behavioral disorder
- ☐ Other (explain) _____

FOR ANY OF THE BOXES CHECKED ABOVE, PLEASE SUBMIT COMPLETE OFFICIAL INPATIENT TREATMENT RECORDS, EVIDENCE OF ONGOING REHABILITATION TREATMENT, AND A PERSONAL WRITTEN EXPLANATION.

25. Have you ever been charged, convicted of, pled guilty or nolo contendere to a misdemeanor or felony in any state? (Do not include traffic violations or citations resulting in fines of $250 or less.) You must include all convictions, including those that have been set aside, and dismissed or expunged, or where a stay of execution has been issued. Yes ☐ No ☐

26. Is any criminal action related to the above now pending? Yes ☐ No ☐

27. Do you have a Drug Enforcement Administration (DEA) number? Yes ☐ No ☐

28. If yes, what is the DEA number and in what state was it issued? _____

29. Has any DEA number ever been restricted, suspended or revoked? Yes ☐ No ☐

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, ATTACH DETAILED EXPLANATION AND SUPPORTING DOCUMENTS.

## CERTIFICATION

**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.**

_____ _____

Signature of Applicant Date

"Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Pub. L. 94-455 (42 U.S.C.A. 405 (c) (2) (C)) authorizes collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 11350.6 of the Welfare and Institutions Code, or for verification of licensure or examination status by a licensing or examination entity which utilized a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."

Photo Area
Paste a recent 2" x 2" (approximate size) photograph here.

Photo must be of your head and shoulder areas only.

## INFORMATION COLLECTION AND ACCESS

Agency requesting information: Osteopathic Medical Board of California, 1300 National Drive, Suite 150, Sacramento, CA 95834, (916) 928-8390.

All items in this application are mandatory; none are voluntary. 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 licensure 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 or law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Executive Director is the custodian of records.

## APPLICANT DECLARATION/SIGNATURE and NOTARY

STATE OF _____

COUNTY OF _____

The applicant, _____ (PLEASE PRINT FULL NAME) , _____ (DATE OF BIRTH) , being first duly sworn upon his/her oath deposes and says: that he/she is the person herein named subscribing to this application; that he/she has read the complete application, knows the full content thereof, and declares that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that he/she is the lawful holder of the degree of Doctor of Osteopathic 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 produced without fraud or misrepresentation or any mistake of which the applicant is aware and that the applicant is the lawful holder thereof. Applicant further states that he/she authorizes all hospitals, institutions, or organizations, his/her references, agencies (local, state, federal or foreign), to release to the Osteopathic 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 the Board in connection with this application; or any further or future investigation by the Board necessary to determine my medical competence, professional conduct or physical or mental ability to safely engage in the practice of osteopathic medicine. He/she further authorizes the Osteopathic 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. He/she further acknowledges that falsification or misrepresentation of any item or response on this application is adequate to deny the same or to hold a hearing to revoke the same, if issued.

**SIGNATURE OF APPLICANT:** _____

Signed and sworn to before me this _____ day of _____ (month) , _____ (year) .

_____
Signature of Notary Public

Notary Seal

_____
Address

My Commission expires _____

OMB.1

State of California Department of Consumer Affairs

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# CERTIFICATION OF COMPLETION OF ACGME POSTGRADUATE TRAINING OR AOA ROTATING INTERNSHIP

To be completed by the facility for all osteopathic medical school graduates commencing their first year postgraduate training on or after July 1, 1990. DO NOT COMPLETE IF PHOTOGRAPH OF APPLICANT IS NOT ATTACHED. Please type or print.

This is to certify_____,
Name of Applicant

a graduate of _____,
Osteopathic Medical School

Formally commenced an accredited postgraduate training program at _____

_____
Name and Address of Facility

in _____ on _____, _____.
Specialty

and satisfactorily **completed** such training on _____, _____.

This training consisted of _____ months of actual clinical instruction and is approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA).

List rotations completed. If service was not rotating, indicate type of straight training performed.

**NOTE** – To qualify for licensure in California, effective July 1, 1990, all applicants will be required to complete at least four months of postgraduate training in general medicine as part of the one year requirement. This general medicine requirement may be satisfied by actual clinical practice, where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months. If general medicine requirement is satisfied by training in a specialty area other than family practice, internal medicine, surgery, pediatrics or obstetrics and gynecology, the Program Director must submit a description of the type of training in sufficient detail to allow the Board to determine if it is acceptable.

| ROTATION | LENGTH OF ROTATION |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

APPLICANT

Attach a recent 2" x 2" (approximate size) photograph of passport quality of your head and shoulders only.
Proof photographs and negatives are not acceptable.

_____
Applicant Signature

**I hereby declare under penalty of perjury** under the laws of the State of California that the statements on this form are true and correct and the facility is approved by the ACGME or the AOA to offer the type and level of training completed by the applicant and that the applicant was trained in an approved ACGME or AOA program.

Name_____
Director of Medical Education

Address_____

**Affix Hospital Seal** _____

Phone Number_____

Date_____

Signature_____

*NOTE: This form cannot be accepted without the Hospital Seal. If your hospital does not have a seal, please have this document notarized. This postgraduate training certification form must be submitted directly from the program to the Osteopathic Medical Board of California.*

Business and Professions Code section 2096 states in part: "In addition to other requirements…before a physician's and surgeon's license may be issued, each applicant…shall show evidence satisfactory to the Board that he or she has satisfactorily completed at least one year of postgraduate training, which includes at least four months of general medicine, in an approved postgraduate training program…"

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# VERIFICATION OF LICENSURE

**(APPLICANT:** PLEASE COMPLETE THE TOP SECTION OF TH IS FORM AND MAIL TO EA CH STATE BOARD WHERE YOU ARE NOW OR HAVE EVER BEEN LICENSED. PLEASE MAKE AS MANY COPIES AS NEEDED.)

To Whom It May Concern:

I am applying for an o steopathic physician a nd surgeon licen se in the State o f California. The Osteopathic Medical Bo ard of Calif ornia requir es that your Board complete this fo rm as part of my application for licensure. By signing this form, I give my consent to release any information, favorable or otherwise. Please forward the completed form directly to the Osteopathic Medical Board of California as soon as possible.

My license number _____ was issued by your State Board on _____.

_____ _____
Signature Address

_____ _____
Printed Name City State Zip

**SECTION BELOW TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD**

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

License Number _____ to practice osteopathic medicine/surgery in the State of _____ was issued to _____ on _____, _____. This license will expire _____, _____.

Is this license current and in good standing? _____ If no, please attach explanation.

Has any disciplinary action ever been taken against this physician? _____ If yes, please attach explanation.

_____ _____ _____
Signature and Title State Board

(_____)_____ _____
Telephone Number Date

(BOARD SEAL)

# REQUEST FOR LIVE SCAN SERVICE

***Applicant Submission***

**ORI:** A0065 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☒ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: PHYSICIAN AND SURGEON

Agency Address Set Contributing Agency:

Osteopathic Medical Board of California — Agency authorized to receive criminal history information

05119 — Mail Code (five-digit code assigned by DOJ)

1300 National Drive, #150 — Street No. Street or PO Box

David Moran — Contact Name (Mandatory for all school submissions)

Sacramento — City

CA — State

95834-1991 — Zip Code

( 916 ) 928-8390 — Contact Telephone No.

Name of Applicant: (Please print) Last First MI

AKA's: Last First

CDL No.

DOB: SEX: ☐ Male ☐ Female

Misc. No. **BIL -** 100124 — Agency Billing Number (if applicable)

HT: WT:

Misc. No.

EYE Color: HAIR Color:

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB:

Street or PO Box

SOC:

City, State and Zip Code

Your Number: OCA No. (Agency Identifying No.)

Level of Service DOJ ☒ FBI ☒

If resubmission, list Original ATI No.

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE — Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( ) Agency Telephone No. (Optional)

Live Scan Transaction Completed By: Name of Operator

Date

Transmitting Agency

ATI No.

Amount Collected/Billed

# REQUEST FOR LIVE SCAN SERVICE

***Applicant Submission***

**ORI:** A0065 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☒ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: PHYSICIAN AND SURGEON

Agency Address Set Contributing Agency:

Osteopathic Medical Board of California
Agency authorized to receive criminal history information

05119
Mail Code (five-digit code assigned by DOJ)

1300 National Drive, #150
Street No. Street or PO Box

David Moran
Contact Name (Mandatory for all school submissions)

Sacramento CA 95834-1991
City State Zip Code

( 916 ) 928-8390
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ☐ Male ☐ Female

Misc. No. **BIL -** 100124
Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____
Street or PO Box

SOC: _____
City, State and Zip Code

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service DOJ ☒ FBI ☒

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE
Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( ) Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

BCII 8016 (Rev10/98) **ORIGINAL-Live Scan Operator; SECOND COPY-Requesting Agency; THIRD COPY-Applicant**

# REQUEST FOR LIVE SCAN SERVICE

***Applicant Submission***

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Job Title or Type of License, Certification or Permit: PHYSICIAN AND SURGEON

Agency Address Set Contributing Agency:

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( 916 ) 928-8390
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First MI

AKA's: _____
Last First

CDL No. _____

DOB: _____ SEX: ☐ Male ☐ Female

Misc. No. **BIL -** 100124
Agency Billing Number (if applicable)

HT: _____ WT: _____

Misc. No. _____

EYE Color: _____ HAIR Color: _____

Home Address: (Applies only if Youth Org/HRA or Public Utility submission)

POB: _____

Street or PO Box

SOC: _____

City, State and Zip Code

Your Number: _____
OCA No. (Agency Identifying No.)

If resubmission, list Original ATI No. _____

Level of Service DOJ ☒ FBI ☒

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

THIS SECTION IS NOT APPLICABLE
Employer Name

Street No. Street or PO Box

Mail Code (five digit code assigned by DOJ)

City State Zip Code

( ) Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____
Name of Operator

Date _____

Transmitting Agency

ATI No.

Amount Collected/Billed

**BCII 8016 (Rev10/98)** **ORIGINAL-Live Scan Operator; SECOND COPY-Requesting Agency; THIRD COPY-Applicant**