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
P (916) 928-8390 F (916) 928-8392 | www.ombc.ca.gov

LICENSING CHECK SHEET

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.4 Verification of Licensure *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 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.*

PHOTOGRAPHS

- Three (3) recent 2" x 2" (approximate size) **passport quality photographs** of your head and shoulders only. All three photographs must be identical. *One affixed to your application form OMB.1, one affixed to your postgraduate training certification form OMB.2, and one 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.

***** If you ordered your Written Exam Verification (board scores), Transcript, and/or Diploma from Federal Credential Verification Services (FCVS), you must provide that 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.

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).

- **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.)

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

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

  Or

- **Fingerprint Cards**
  Applicants residing 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. Please provide your mailing address where you wish the fingerprint cards to be mailed. Results from the manual card process can take up to 16 weeks.

  Manual Fingerprint Process

  a. Contact the OMBC to obtain two fingerprint cards.
  b. Complete all applicable areas on both cards (refer to instruction sheet included with the cards).
  c. Take the completed cards to a local law enforcement office and have your fingerprints rolled.
  d. 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

- Mail one check for $249 (Application Processing Fee: $200, Fingerprint Processing Fee: $49)
  - **Make check or money order payable to the Osteopathic Medical Board of California.**
  - **Application and fingerprint processing fees are nonrefundable**.

REQUIREMENTS FOR LICENSURE

The Board is now accepting individual taxpayer identification numbers (ITINs) for an applicant that does not have a social security number (SSN).

You MUST complete your first year postgraduate training and have successfully completed all three levels of the NBOME/COMLEX in order to apply for a license.

The Board shall determine that no disciplinary action has been taken against the applicant by any medical licensing authority or that 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.

The review and approval process may 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.

Temporary licenses are **not** available.

GENERAL INFORMATION

- We can only discuss your application status with you and those persons whom you designate.
- You will be notified of the status of your application, including any deficiencies, generally within 30 days from the date your application is received by the Board.
- Your application is considered complete once all required forms, documentation, DOJ and FBI fingerprint clearances, and appropriate fees have been received and approved.
- Once your application has been approved, you will be notified as to the amount of the license fee you will need to remit. The 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 and the date the fee is billed.
- If your application is denied by the Osteopathic Medical Board of California, you will be notified in writing of 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. Fees will not be refunded.

CONTACT INFORMATION CHANGES

It is your responsibility to notify OMBC, in writing, of any address, e-mail, or name changes made during the application process.

HONORABLY DISCHARGED MILITARY AND MILITARY SPOUSE

To expedite the initial licensure process, persons honorably discharged from the military must submit a copy of their DD214. 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 base in California.

Medically Underserved

If you are applying for a license in California, will be practicing primary care, and your potential employer is located in an area established as medically underserved* by the Office of Statewide Healthcare Planning & Development, you must provide the Osteopathic Medical Board with

- a letter of intent to hire from your potential employer AND
- a letter requesting expedited processing of your license application.

Reference:
Business and Professions Code Section 2099.6.

(a) The Osteopathic Medical Board of California shall develop a process to give priority review status to the application of an applicant for an osteopathic physician and surgeon's certificate who can demonstrate that he or she intends to practice in a medically underserved area or serve a medically underserved population as defined in Section 128565 of the Health and Safety Code.

(b) An applicant may demonstrate his or her intent to practice in a medically underserved area or serve a medically underserved population by providing proper documentation, including, but not limited to, a letter from the employer indicating that the applicant has accepted employment and stating the start date.

*
http://www.oshpd.ca.gov/HWDD/MSSA/GIS/HPSA_PrimaryCare.pdf

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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 unless otherwise indicated.
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.

1. NAME: Last:	First:	Middle:
OTHER NAMES USED if any:		2. SOCIAL SECURITY NO. OR INDIVIDUAL TAXPAYER ID 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 (optional):	

8. PRE-OSTEOPATHIC COLLEGE(S)	ADDRESS	DATES OF ATTENDANCE

9. OSTEOPATHIC COLLEGE(S)	ADDRESS	DATES OF ATTENDANCE:
		DATE OF DEGREE:

10. POSTGRADUATE TRAINING INTERNSHIP (AOA) — Hospital Name | Address | Type of Service | Dates of Attendance

RESIDENCY/FELLOWSHIP: — Dates of Service

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

12. LIST ALL WRITTEN EXAMINATIONS TAKEN e.g. NBOME, State Written Boards, USMLE, FLEX etc. B & P 2099.5

STATE WHICH EXAMINATIONS AND WHERE TAKEN	DATE COMPLETED

13. 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

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

15. Are you married to, or in a domestic partnership or other legal union, with an active duty member of the US military officially assigned to a duty station in California? Yes ☐ No ☐

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

17. 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 ☐

18. 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 ☐

19. Have you ever withdrawn an application from any hospital, public entity or licensing agency? If Yes, When? Yes ☐ No ☐

20. 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 ☐

21. Have you ever had a medical or any healing art license restricted, suspended, revoked, disciplined or denied in any state? Yes ☐ No ☐

22. Have you ever been denied permission to practice medicine or any healing art in any state? Yes ☐ No ☐

23. 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.

24. Have you ever been convicted of, or pled guilty or nolo contendere to ANY criminal or civil offense in the United States, its territories, or a foreign country? This includes every citation, infraction, misdemeanor and/or felony, including traffic violations. Convictions that were adjudicated in the juvenile court or convictions under California Health and Safety Code Sections 11357 (b), (c), (d), (e), OR section 11360 (b) which are two years or older should NOT be reported. Convictions that were later dismissed pursuant to sections 1203.4, 1203.4a, or 1204.41 of the California Penal Code or equivalent non-California law MUST be disclosed.

Yes ☐ No ☐

Proof of Dismissal: If you have obtained a dismissal of your conviction(s) pursuant to Penal Code sections 1203.4, 1203.4a, or 1203.41, please submit a certified copy of the court order dismissing the conviction(s) with your application.

25. Is any criminal action related to the above now pending? 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 - Sign in Presence of the Notary Date

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

Photo must be of your head and shoulder areas only. CCR 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 DECLARATION/SIGNATURE and NOTARY

State of California

County of _____

On _____ before me, _____(insert name and title of officer),

personally appeared, _____ who proved to me on the basis of satisfactory evidence to

be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the forgoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

Notary Seal

_____
Address

My Commission expires _____

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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 –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.

Affix Hospital Seal

Name _____
Director of Medical Education

Address _____

_____

Phone _____

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 THIS FORM AND MAIL TO EACH 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 osteopathic physician and surgeon license in the State of California. The Osteopathic Medical Board of California requires that your Board complete this form 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

_____ Printed Name

_____ Address

_____ 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 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.)

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

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City State Zip Code

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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 ☒

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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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Last First

CDL No. _____

DOB: _____ SEX: ☐ Male ☐ Female

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SOC: _____

City, State and Zip Code

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Name of Operator

Date _____

Transmitting Agency ATI No. Amount Collected/Billed

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