



APPLICATION FOR DUPLICATE LICENSE / CERTIFICATE

FOR PMBC USE ONLY

Fee paid: _____	Receipt #: _____
Date Cashiered: _____	Cashier's Initials: _____
Date Approved: _____	Date Denied: _____
Approved Initial: _____	

If you need a duplicate license of a Doctor of Podiatric Medicine permanent or resident license, you may purchase a replacement from the Board online through: <https://www.breeze.ca.gov/> or by mailing this form to the Board along with a \$100 check or money order made payable to the *Podiatric Medical Board of California*. Please provide all information requested below.

Please print or type. Illegible applications will be returned.

LICENSEE INFORMATION:

LICENSE NUMBER:	E-MAIL/PHONE NUMBER:
DATE OF BIRTH:	EXPIRATION DATE:

NAME:

The address of record will not be displayed on the Podiatric Medical Board of California's website.

STREET ADDRESS

CITY	STATE	ZIP CODE	COUNTRY
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Please provide the following information:

Request for Duplicate:	<input type="checkbox"/> Wall Certificate	<input type="checkbox"/> Wallet (pocket) license
License Type:	<input type="checkbox"/> Permanent license	<input type="checkbox"/> Resident license
Check all that apply:	<input type="checkbox"/> Lost	<input type="checkbox"/> Stolen
	<input type="checkbox"/> Mutilated	<input type="checkbox"/> Destroyed
	<input type="checkbox"/> Name Change	<input type="checkbox"/> Address Change

Provide an explanation of the circumstances of the loss:

PHOTOGRAPH:

Photograph

Affix a 2" x 2" Photo Here

Photo Must Be Recent and
Must Be of your Head and
Shoulder Areas Only

Altered Photographs
are NOT acceptable

I hereby declare under penalty of perjury under the laws
of the state of California, that the photo of myself
attached hereto, was taken on or about _____.

My age then being _____ years.

Hair color _____

Eye color _____

Height _____

Weight _____

Identifying marks _____

Upon receipt of this application and the fees, a request for a duplicate license will be submitted. This is a controlled document and is not printed in our office, rather through another state agency. You should receive your certificate in the mail within 2-3 weeks.

I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA TO THE TRUTH AND ACCURACY OF THE ABOVE INFORMATION.

Name (Please print)

License Number

Signature

Date

Signature and date are required to process this request.

All items in this application are mandatory; none are voluntary. This information is requested by the Licensing Program of the Podiatric Medical Board of California. Failure to provide any of the requested information may result in this application being rejected as incomplete. The Executive Officer is the custodian of records. Access to records by the individual to whom they pertain may be obtained under the Information Practices Act by contacting the custodian of records at 2005 Evergreen Street, Suite 1300, Sacramento, CA 95815. Information in this application may be transferred to other governmental and law enforcement agencies.

This form must be mailed to the board at 2005 Evergreen St., Ste. 1300, Sacramento, CA 95815