

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
 CYPRESS RIDGE BUILDING • 1867 CRANE RIDGE DRIVE, SUITE 200-B • JACKSON, MS 39216
 (601) 987-3079
 WWW.MSBML.MS.GOV

FAX NOT ACCEPTABLE

APPENDIX A

STATE PODIATRY BOARD LICENSURE CERTIFICATION

Name of State Podiatry Board	
State Podiatry Board Address	
City, State, Zip	

Name of Applicant	
Applicant Address	
City, State, Zip	

Podiatric License #		Current Status	
Area of Specialty		Type of License	
Issue Date		Expiration Date	

Licensure Base		Endorsement		Reciprocity		State Board
		NBPME		PM Lexis		

Has applicant's license ever been suspended, revoked or had restrictions imposed? (If yes, please attach documents.)
Is applicant currently under investigation for any reason? (If yes, please explain.)

Signature of Certifying Official			
Title		Signature Date	
Email address		Telephone No.	

INSTRUCTIONS TO INDIVIDUAL COMPLETING THIS FORM:

Please fill in all applicable spaces and return to the Mississippi State Board of Medical Licensure at the above address or email a PDF format to certification@msbml.ms.gov. Do not send this certification back to the applicant as the Board will not consider the certification unless it is received directly from the institution. Board policy requires original documents from primary source. A fax is not acceptable.

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APPENDIX B

ACTIVITY CERTIFICATION

Name of Applicant								
Name of Employer								
Employer Address								
City, State, Zip								
Position/Title of Applicant								
Type of Activity		Medical		Non-Medical		Educational		
Activity Status		Inactive		Active		Volunteer		Other
Dates of Activity	From:			To:				
Was applicant ever placed on probation, disciplined, placed under investigation, or asked to resign? (If yes, please explain)							<input type="checkbox"/> Yes	
							<input type="checkbox"/> No	
Were any limitations or special requirements placed upon applicant because of questions of incompetence, disciplinary problems or any other reasons? (If yes, please explain)							<input type="checkbox"/> Yes	
							<input type="checkbox"/> No	
Was applicant in good standing during the above stated period of time? (If no, please explain)							<input type="checkbox"/> Yes	
							<input type="checkbox"/> No	
Did applicant take any type of leave of absence or break from this activity? (If yes, please explain)							<input type="checkbox"/> Yes	
							<input type="checkbox"/> No	
Signature of Certifying Official								
Title				Signature Date				
Email address				Telephone No.				

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APPENDIX C

STAFF MEMBERSHIP CERTIFICATION

Name of Applicant						
Name of Hospital, Clinic or Facility						
Hospital, Clinic or Facility Address						
City, State, Zip						
Position/Title of Applicant						
Type of Membership		Employee		Staff Member		Locum Tenens
		Instructor		Emergency Room		Other
Dates of Membership	From:			To:		
Was applicant ever placed on probation, disciplined, placed under investigation, or asked to resign? (If yes, please explain)	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Were any limitations or special requirements placed upon applicant because of questions of incompetence, disciplinary problems or any other reasons? (If yes, please explain)	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Was applicant in good standing during the above stated period of time? (If no, please explain)	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Did applicant take any type of leave of absence or break from membership? (If yes, please explain)	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Signature of Certifying Official						
Title				Signature Date		
Email address				Telephone No.		

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APPENDIX D

PERPETUAL AUTHORIZATION TO RELEASE INFORMATION

Name of Applicant			
<p>The undersigned applicant for a podiatry license in the State of Mississippi, hereby authorizes each educational institution at which the undersigned has applied for any license, permit, certificate or registration; each person, firm, corporation, clinic, office, or institution by whom or with whom the undersigned has been employed as a podiatrist; each insurance company with which the undersigned has obtained or made application for medical malpractice liability insurance; each physician or other health care practitioner with whom the undersigned has consulted or seen for diagnosis or treatment; and each professional organization or specialty board to which the undersigned has applied for membership, to disclose and release to the Mississippi State Board of Medical Licensure, 1867 Crane Ridge Drive, Suite 200-B, Jackson, MS 39216, any and all information and documentation concerning the undersigned which the Board deems material for consideration of his/her application. Further, the undersigned hereby consents to the disclosure and release of such information and documentation to the Mississippi State Board of Medical Licensure and waives any privilege or right of confidentiality which the undersigned would otherwise possess with respect thereto.</p> <p>The undersigned hereby authorizes any person, firm, corporation, clinic, office, institution, state or federal agency from whom the Mississippi State Board of Medical Licensure has requested information to rely on a copy of this release, the original now on file in the office of the Mississippi State Board of Medical Licensure at the above noted address.</p> <p>The undersigned also agrees to execute any other release or authorization, the execution of which may be required under federal or state law prior to release of any of the documents or information requested. Otherwise, this authorization shall constitute a complete and perpetual release and authorization for all purposes set forth therein.</p>			
Signature of Applicant			
Printed Name of Applicant		Signature Date	
Sworn to and subscribed to before me this the _____ day of _____, 20____.			
<u>My Commission Expires:</u>	_____ Notary Public		

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Cypress Ridge Building • 1867 Crane Ridge Drive, Suite 200-B • Jackson, MS 39216
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APPENDIX E

**REQUEST FOR MEMBERSHIP VERIFICATION
FROM THE AMERICAN PODIATRIC MEDICAL ASSOCIATION**

TO APPLICANT:

Please complete the following information and submit to the American Podiatric Medical Association, ATTN: Membership Services Dept., 9312 Old Georgetown Road, Bethesda, Maryland, 20814, along with a check or money order in the amount of \$15.00.

Full Name of DPM _____

Professional Mailing Address _____

Place of Birth _____ Date of Birth _____

Podiatric School of Graduation _____

TO AMERICAN PODIATRIC MEDICAL ASSOCIATION:

In order to obtain a Mississippi Medical License, I must have a Membership Verification from you. Enclosed is a \$15.00 check or money order to cover the processing fee. Please accept this as my request to send a Membership Verification to the Mississippi State Board of Medical Licensure, 1867 Crane Ridge Drive, Suite 200-B, Jackson, Mississippi 39216.

Physician Signature

Date

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APPENDIX G

DISCIPLINARY SEARCH REPORT

Federation of Podiatric Medical Boards
ATTN: Larry Shane, Executive Director
Post Office Box 740525
Boynton Beach, Florida 33474-0525

The Mississippi State Board of Medical Licensure requests a disciplinary search concerning the following individual:

NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

PODIATRY SCHOOL: _____

DATE OF GRADUATION: _____

Enclosed is the processing fee of \$40.00. Please mail the response to the following address:

W. Joseph Burnett, M.D., Executive Director
Mississippi State Board of Medical Licensure
1867 Crane Ridge Drive, Suite 200-B
Jackson, Mississippi 39216

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