

**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 F**

**MALPRACTICE INSURANCE CERTIFICATION**

Name of Applicant			
Name of Insurance Carrier			
Name of Insurance Agency			
Agency Address			
City, State, Zip			
Policy Number			
Dates of Coverage	From:	To:	
Have any specific procedures been excluded from this coverage? (If yes, please explain)			
			<input type="checkbox"/> Yes
			<input type="checkbox"/> No
Are there any current pending judgments or settlements on behalf of this provider? (If yes, please explain)			
			<input type="checkbox"/> Yes
			<input type="checkbox"/> No
Have there been any paid judgments or settlements on behalf of this provider? (If yes, please explain)			
			<input type="checkbox"/> Yes
			<input type="checkbox"/> No
Have any professional liability suits been defended for this provider? (If yes, please explain)			
			<input type="checkbox"/> Yes
			<input type="checkbox"/> No
<b>If any of the above questions are “Yes”, please provide a claims history report and an explanation of the details on a separate sheet.</b>			
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](mailto: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.**