

**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 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.		

**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.**