

**MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE**  
**1867 CRANE RIDGE DRIVE, SUITE 200-B**  
**JACKSON, MISSISSIPPI 39216**  
**(601) 987-3079**

**APPLICATION FOR CERTIFICATE TO PRACTICE MEDICINE**

**GENERAL INFORMATION**

1. NAME IN FULL \_\_\_\_\_  
(FIRST) (MIDDLE) (LAST) (DEGREE)
2. ADDRESS \_\_\_\_\_  
(STREET OR P O BOX) (CITY) (STATE) (ZIP)
3. PLACE OF BIRTH \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
(CITY AND STATE OR COUNTRY) (MO/DA/YR)
4. SOCIAL SECURITY NUMBER \_\_\_\_\_ GENDER \_\_\_\_\_
5. TELEPHONE (W) \_\_\_\_\_ (H) \_\_\_\_\_ FACSIMILE \_\_\_\_\_
6. E-MAIL ADDRESS \_\_\_\_\_
7. U. S. DEA NUMBER \_\_\_\_\_ NPI NUMBER \_\_\_\_\_

**AFFIDAVIT QUESTIONS**

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Have you ever been convicted of a felony?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been convicted of any violation of a state or federal law relating to controlled substances?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are any charges against you for violation of state or federal drug laws currently pending in any court?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been denied a state or federal controlled substances certificate or have had such a certificate revoked, restricted, conditioned or curtailed?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever surrendered a state or federal controlled substance certificate for any reason?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, conditioned, curtailed or voluntarily surrendered under threat of suspension or revocation?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever resigned from the medical staff of any hospital or health care facility while an investigation or disciplinary proceeding was being conducted or pending?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you now, or have you ever used any controlled substances or other drugs having addiction-forming or addiction-sustaining liability to the extent it affects your ability to practice medicine with reasonable skill and safety to patients?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever prescribed to yourself any controlled substance or other drug having addiction-forming or addiction-sustaining liability, or obtained said medications for your own use and consumption through any sources, other than by prescription or order of a licensed physician?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Are you now, or have you ever consumed alcohol or other intoxicating liquors to the extent it affects your ability to practice medicine with reasonable skill and safety to patients?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. If your answer to any one of the three preceding questions is "yes", are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in illegal use of controlled substances or other drugs having addiction-forming or addiction-sustaining liability? | <input type="checkbox"/> | <input type="checkbox"/> |

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 15. During any postgraduate training were you ever on probation, restrictions, suspension, revocation, modification, or otherwise acted against (explain "otherwise" actions)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever been diagnosed as having, or have you ever been treated for, pedophilia, exhibitionism, or voyeurism, bipolar disorder, sexual disorder, schizophrenia, paranoia or other psychiatric disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had a malpractice claim made or suit filed against you pertaining to any aspect of your medical practice, regardless of whether or not such a claim was dismissed, never pursued, settled, resulted in a favorable or adverse judgment, or is now pending? Please use separate sheet to address each claim or suit. | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever been denied medical malpractice liability insurance?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. To your knowledge, have you ever been or are you now, the subject of an investigation or disciplinary proceeding by any licensing Board/Agency as of the date of this application?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever been arrested, other than minor traffic citations?  | <input type="checkbox"/> | <input type="checkbox"/> |

**IF ANY OF THE ABOVE ANSWERS ARE IN THE AFFIRMATIVE, PLEASE EXPLAIN IN DETAIL ON AN ATTACHED SHEET.**

21. Have you ever applied for, or been denied a Mississippi medical license? \_\_\_\_\_
22. Have you ever served in the US Military? \_\_\_\_\_ Branch \_\_\_\_\_ Dates \_\_\_\_\_
23. Do you currently have an anticipated date to begin practice in Mississippi? \_\_\_\_\_ Date \_\_\_\_\_

### I. PRACTICE NAME AND PRACTICE LOCATIONS

List name as appears at each current practice location-Solo, Group, Hospital, etc. Number 1 should be your "Primary" practice location (where you spend the majority of your practice time.) Number 2 should be your "Intended" Mississippi practice location. Number 3 may be used for additional practice location.

	Practice Name	Address	City, State, Zip
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

### II. MEDICAL EDUCATION

List all medical schools attended, dates and complete addresses of institutions. Do not list internship and/or residency training.

	Date	Name	Address	City/State
1.	_____ to _____	_____	_____	_____
2.	_____ to _____	_____	_____	_____
3.	_____ to _____	_____	_____	_____

### III. INTERNSHIP, RESIDENCY AND/OR FELLOWSHIP TRAINING

(Do not list practice experience)

List in chronological order all internship, residency, and/or fellowship training since graduation from medical school with dates and complete addresses of institutions. Specify training program, i.e., Family Practice, OB/GYN, etc.

	Date	Hospital/Institution	City/State	Training Program
1.	_____ to _____	_____	_____	_____
2.	_____ to _____	_____	_____	_____
3.	_____ to _____	_____	_____	_____
4.	_____ to _____	_____	_____	_____
5.	_____ to _____	_____	_____	_____

### IV. ACTIVITIES FOLLOWING MEDICAL SCHOOL AND TRAINING

List all practice experience in chronological order since completion of your formal training giving dates, institutions/hospitals, and complete addresses. If any period did not include practice experience, give explanation. All activities following medical school and training must be accounted for. Use separate sheet if necessary.

Date	Place	Address	City/State
1. _____ to _____	_____	_____	_____
2. _____ to _____	_____	_____	_____
3. _____ to _____	_____	_____	_____
4. _____ to _____	_____	_____	_____
5. _____ to _____	_____	_____	_____
6. _____ to _____	_____	_____	_____
7. _____ to _____	_____	_____	_____
8. _____ to _____	_____	_____	_____
9. _____ to _____	_____	_____	_____
10. _____ to _____	_____	_____	_____
11. _____ to _____	_____	_____	_____
12. _____ to _____	_____	_____	_____
13. _____ to _____	_____	_____	_____
14. _____ to _____	_____	_____	_____
15. _____ to _____	_____	_____	_____

### V. HOSPITAL PRIVILEGES

List all hospitals in chronological order where you have held staff privileges of any type. Post-graduate training sites should not be listed. Use a separate sheet if necessary.

Date	Place	Address	City/State
1. _____ to _____	_____	_____	_____
2. _____ to _____	_____	_____	_____
3. _____ to _____	_____	_____	_____
4. _____ to _____	_____	_____	_____
5. _____ to _____	_____	_____	_____
6. _____ to _____	_____	_____	_____
7. _____ to _____	_____	_____	_____
8. _____ to _____	_____	_____	_____
9. _____ to _____	_____	_____	_____
10. _____ to _____	_____	_____	_____

### VI. REFERENCES

List two physicians (other than family members) licensed in the United States or Canada with whom you have worked or trained within the last two years. Two physicians must be listed with complete addresses. All incomplete applications will be returned.

Physician Name	Street or P.O. Box	City, State & Zip
1. _____	_____	_____
2. _____	_____	_____

**VII. STATE LICENSURE**

List all states where you have been licensed to practice medicine or have applied for a license to practice medicine. Include active and/or expired, limited, restricted, temporary, educational or training licenses. Use a separate sheet if necessary.

License Number	State	Year Issued	License Number	State	Year Issued
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**VIII. LICENSING EXAMINATION AND SPEX**

1. List dates, scores, and state where licensing examination was taken: (If dates and scores are unknown, indicate which examination was taken).

	Date	Score	State
State Board Examination	_____	_____	_____
FLEX Weighed Average	_____	_____	_____
FLEX			
Component I	_____	_____	_____
Component II	_____	_____	_____
USMLE			
Step I	_____	_____	_____
Step II	_____	_____	_____
Step III	_____	_____	_____
National Board of Medical Examiners			
Part I	_____	_____	_____
Part II	_____	_____	_____
Part III	_____	_____	_____
National Board of Osteopathic Examiners	_____	_____	_____
LMCC	_____	_____	_____
Special Purpose Examination	_____	_____	_____

- Was FLEX weighed average obtained in a single administration of the entire 3-day exam? \_\_\_\_\_
- Have you failed an examination, including FLEX, SPEX or USMLE, before any State Board? \_\_\_\_\_  
If yes, name the board and give the date of the examination. \_\_\_\_\_
- Have you successfully completed a written licensing examination within the last ten years? \_\_\_\_\_
- Are you certified by an ABMS or AOA approved Specialty Board? \_\_\_\_\_ *If so, have the Specialty Board send verification of your certification directly to this Board.*
- VQE, Permanent ECFMG Certificate or FMGEMS Number \_\_\_\_\_ Date Issued \_\_\_\_\_

**IX. MEDICAL MALPRACTICE INSURANCE**

List names and addresses of insurance carriers from whom you have ever obtained medical malpractice liability insurance. Use a separate sheet if necessary.

Name	Address	City/State
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

**X. AFFIDAVIT AND RELEASE**

I, \_\_\_\_\_, certify after being duly sworn, that all of the information supplied in the foregoing application is true and correct to the best of my knowledge, that the photograph submitted herein is a true likeness of myself and was taken within sixty (60) days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation of any license to practice medicine granted to me and criminal prosecution to the fullest extent of the law.

I further authorize the release of this application and any information submitted with it or information collected by the Mississippi State Board of Medical Licensure in connection with this application, including derogatory information, to any person or organization having a legitimate need for the information and release the Mississippi State Board of Medical Licensure from all liability for the release of this information.

I further authorize the release of information, including derogatory information, which may be in the possession of other individuals or organizations to the Mississippi State Board of Medical Licensure and release this person or organization from any liability for the release of information.

Date \_\_\_\_\_ Applicant's Signature \_\_\_\_\_

County of \_\_\_\_\_

State of \_\_\_\_\_

SWORN to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, in the year of \_\_\_\_\_.

(SEAL)

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

**PHOTOGRAPH**  
(wallet-size, passport-type)  
**TAKEN WITHIN**  
**SIXTY (60) DAYS**  
must be attached here with  
tape. Do not paste.  
**COMPUTER GENERATED OR**  
**INFORMAL SNAPSHOTS**  
**WILL NOT BE ACCEPTED**

**FOR USE OF MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE ONLY**

INVESTIGATOR INTERVIEWER: \_\_\_\_\_

DATE: \_\_\_\_\_

PERMANENT LICENSE NUMBER: \_\_\_\_\_

ISSUED ON: \_\_\_\_\_

WALL CERTIFICATE MAILED: \_\_\_\_\_