MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
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(601) 987-3079
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FAX NOT ACCEPTABLE

APPENDIX A

PODIATRY SCHOOL CERTIFICATION

Name of Podiatrist			
Name of Institution			
Institution Address			
City, State, Zip			
Country			
Total number of weeks of podiatry education			
Dates of Attendance		From:	To:
Type of Degree		Award Date of Degree	
Was podiatrist ever dropped, suspended, placed on probation, or asked to resign? (If yes, please explain)			☐ Yes ☐ No
Did the podiatrist attend podiatry school for a period other than the normal curriculum, or was he/she required to repeat any podiatry education? (If yes, please explain)			☐ Yes ☐ No
Did podiatrist take any type of break or leave of absence for any reason during podiatry school? (If yes, please explain)			☐ Yes ☐ No
Signature of certifying official		School Seal	
Title			
Email address			
Date of signature			

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. Do not send this certification back to the applicant. The Board will not consider the certification unless it is received directly from the institution. Board policy requires original documents from primary source. Do not fax or email.