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 E**

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)	☐ Yes ☐ No	
Are there any current pending judgments or settlements on behalf of this provider? (If yes, please explain)	☐ Yes ☐ No	
Have there been any paid judgments or settlements on behalf of this provider? (If no, please explain)	☐ Yes ☐ No	
Have any professional liability suits been defended for this provider? (If yes, please explain)	☐ Yes ☐ No	
If any of the above questions are "Yes", please provide a claims history report and an explanation of the details on a separate sheet.		

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.