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

For Office Use Only
Check #_____
Amount_____
Application #_____

APPLICATION FOR REINSTATEMENT OF LICENSE TO PRACTICE AS A PHYSICIAN ASSISTANT

Type or Print Legibly

Personal Information

Fields in **bold** are required information.

Last Name	**First Name**	Middle Name	**Degree**
Alternate Names *(if any)*			
***Address (Street or P O Box)**			
City		**State**	**Zip**

Place of Birth (City & State or Country)	**Date of Birth (Month/Day/Year)**	
Social Security Number	**Gender**	
U.S. DEA Number	NPI Number	
Work Phone	Facsimile	**Home Phone**
Email Address		
Physician Assistant School		**Date of Graduation**
Mississippi License Number	**Expiration Date**	**Issue Date**

***The Board will use this address for all correspondence.**

Affidavit Questions

Answer questions by circling "Yes" or "No". If any of the following answers are in the affirmative, explain in detail on a separate sheet.

1.	Have you ever been convicted of a felony?	Yes No
2.	Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice as a physician assistant?	Yes No
3.	Have you ever been convicted of any violation of a state or federal law relating to controlled substances?	Yes No
4.	Are any charges against you for violation of state or federal drug laws currently pending in any court?	Yes No

5.	Have you ever been denied a state or federal controlled substances certificate or have had such a certificate revoked, restricted, conditioned or curtailed?	Yes No
6.	Have you ever surrendered a state or federal controlled substance certificate for any reason?	Yes No
7.	Has your certificate of qualification or license to practice as a physician assistant in any state been suspended, revoked, restricted, conditioned, curtailed or voluntarily surrendered under threat of suspension or revocation?	Yes No
8.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?	Yes No
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?	Yes No
10.	Have you ever been denied a certificate of qualification or license to practice as a physician assistant in any state, or has your application for a certificate of qualification or license to practice as a physician assistant been withdrawn under threat of denial?	Yes No
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 as a physician assistant with reasonable skill and safety to patients?	Yes No
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 or other healthcare provider authorized to prescribe?	Yes No
13.	Are you now, or have you ever consumed alcohol or other intoxicating liquors to the extent it affects your ability to practice as a physician assistant with reasonable skill and safety to patients?	Yes No
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?	Yes No
15.	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?	Yes No
16.	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? Use separate sheet to address each claim or suit.	Yes No
17.	Have you ever been denied medical malpractice liability insurance?	Yes No
18.	To your knowledge 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?	Yes No
19.	Have you ever been arrested, other than minor traffic citations?	Yes No
20.	Have you ever served in the US Military? If yes, Branch_____ Dates_____	Yes No

Any investigation during the application process must be reported to the Board immediately.

Practice Names and Practice Locations

List name as appears at each current practice location-Solo, Group, Hospital, etc.

Primary Practice	Address	City/State/Zip
Intended Practice	**Address**	**City/State/Zip**
Additional Practice	**Address**	**City/State/Zip**

Activities Following Medical School and Training

List **in chronological order** all practice experience since issuance of MS physician assistant license. If any period did not include practice experience, give explanation. **All** activities **must** be accounted for. Use separate sheet if necessary.

Date (From/To)	Activity	Address	City/State/Zip
1. _____/_____			
2. _____/_____			
3. _____/_____			
4. _____/_____			
5. _____/_____			
6. _____/_____			
7. _____/_____			
8. _____/_____			

Hospital Privileges

List **in chronological order** all hospitals where you have held staff privileges of any type since issuance of MS physician assistant license. Use separate sheet if necessary

Date (From/To)	Name	Address	City/State/Zip
1. _____/_____			
2. _____/_____			
3. _____/_____			
4. _____/_____			
5. _____/_____			
6. _____/_____			
7. _____/_____			
8. _____/_____			
9. _____/_____			
10. _____/_____			
11. _____/_____			
12. _____/_____			

State Licensure

List **ALL** states where you have been licensed to practice as a physician assistant or have applied for a license to practice as a physician assistant. 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

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 as a physician assistant 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 _____.

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

_____

Notary Public

My Commission Expires: _____

(SEAL)

FOR USE OF MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE ONLY

INVESTIGATOR INTERVIEWER: _____

DATE OF INTERVIEW: _____

Reset

REQUEST FOR REINSTATEMENT OF LICENSE
TO PRACTICE AS A PHYSICIAN ASSISTANT
IN THE STATE OF MISSISSIPPI

TO: H. Vann Craig, M.D.
Executive Director
Mississippi State Board of Medical Licensure
1867 Crane Ridge Drive, Suite 200-B
Jackson, Mississippi 39216

I, _____
(First) (Middle) (Last)

whose Mississippi License Number_____ to practice as a physician assistant has lapsed because (explanation for failure to renew license as required by law)

_____

_____

_____

_____

_____

_____

_____ .

I wish to have my license reinstated.

My completed Application for Reinstatement and a fee of $_____ (a check or money order be made payable to the Mississippi State Board of Medical Licensure) are enclosed as required by law.

_____
Signature

Date: _____

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

Reinstatement Requirements

March 2001

Any physician assistant not practicing in Mississippi who allows his license to lapse by failing to renew the license may be reinstated by the board on satisfactory explanation for the failure to renew, by completion of a reinstatement form and upon payment of the arrearage for the previous five (5) years plus the current year and shall be assessed a fine of Twenty-five Dollars ($25.00) per year plus an additional fine of Five Dollars ($5.00) for each month that the license remains delinquent.

IMPORTANT

Upon submission of an application for licensure to the Board, the applicant shall promptly provide all information deemed necessary by the Board to process the application, including, but not limited to letters of recommendation, certification of graduation from medical school, photograph of applicant, internship certificate and birth certificate. The Board shall have a reasonable period of time within which to collect and assimilate all required documents and information necessary to issue a medical license. If, after submitting an application for medical license, an applicant has failed to respond or make a good faith effort to pursue licensure for a period of three (3) months, the application will be considered null and void, and applicant will have to reapply for licensure, including, but not limited to, all fees, application, certifications, and references. Additionally, if after one year from the date of receipt of application, applicant has not received a medical license, the application will be considered null and void, and applicant will have to reapply for licensure, including, but not limited to, all fees, application, certifications, and references. Under no circumstances will the one year time limit be waived.

Duplicate as many copies of each appendix as you need. Primary source verifications are required. The Board does not accept electronic submissions (faxes, emails, etc.), copies, or third party mailing.

A. Appendix A. Applicant must complete top portion and forward one to each state in which he/she holds or has held a license to practice as a physician assistant. Include temporary, limited, restricted, revoked, active and inactive licenses. This form will be accepted only if sent directly from the state board to the Mississippi Board. Do not have the state board send this form back to you.

B. Appendix B. Applicant must account for all time since initial issuance of MS physician assistant license. All activities following initial issuance of MS physician assistant license must be accounted for. Each activity must be verified by the institution. Applicant shall send this form to the institution where activities were performed. This form will be accepted only if sent directly from the institution to the Board. Do not have the institution send this form back to you.

C. Appendix C. Applicant shall make copies from original and forward to each hospital where he/she holds or has held staff privileges. This form will be accepted only if sent directly from the hospital to the Mississippi Board. Do not have the hospital send this form back to you.

D. Appendix D. Applicant must sign and have notarized the "Perpetual Authorization to Release Information" form. A copy of this form must be included with each hospital privilege form that is sent to a hospital. The **original** "Perpetual Authorization to Release Information" form must be returned to the Mississippi State Board of Medical Licensure.

E. Military Records. If applicant has ever served in any branch of the military, applicant must request DD214 Form or its equivalent to be sent to the Board at http://www.archives.gov/veterans/military-service-records/get-service-records.html. The Board will accept a notarized (see notary guide) copy of DD214 Form from the applicant.

F. Application Fees. Applicant must submit check or money order made payable to the MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE in the amount of $250.00. This $250.00 is a non-refundable filing fee, but will be applied to the total reinstatement fee once application has been completed.

NO FOREIGN CHECKS OR MONEY ORDERS WILL BE ACCEPTED.
A $50.00 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS.

MEMORANDUMS CONTAINING DOCUMENTS MISSING FROM APPLICANT'S FILE WILL BE MAILED OUT WEEKLY.

Notary Guide

March 2001

When having your application, birth certificate, passport, or any other documents notarized, please use the following checklist as a guide to ensure proper notarization.

All documents require the following:

1. Notary's stamp or seal
2. Notary's name
3. Notary's signature
4. Notary's commission expiration date
5. Date of notarization (must be original and dated within the last six (6) months)

Documents which must be certified require the notary to certify that the document is a "true & correct copy of the original." If the notary will not certify the document, you may attest that it is a "true & correct copy of the original" and sign the statement. The notary may then notarize your signature.

The notary may attach an affidavit, or cover sheet, if he/she chooses. Some states require an affidavit be used instead of notarizing the actual document. Affidavits must also meet the above checklist requirements and be attached to the document.

If your document is not in English, it must be translated into English. This translation must also be notarized as outlined above. The translation and the original language document must both be notarized and submitted.

Please submit only photocopies of your documents. DO NOT SUBMIT ORIGINAL DOCUMENTS.

Photocopies of the notarization will **NOT** be accepted.

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FAX NOT ACCEPTABLE **APPENDIX A**

STATE MEDICAL BOARD LICENSURE CERTIFICATION

Name of State Medical Board	
State Medical Board Address	
City, State, Zip	

Name of Applicant	
Applicant Address	
City, State, Zip	

Medical License #		Current Status	
Area of Specialty		Type of License	
Issue Date		Expiration Date	

Licensure Base		Endorsement		Reciprocity		State Board
		NCCPA		Other		

Has applicant's license ever been suspended, revoked or had restrictions imposed? (If yes, please attach documents.)
Is applicant currently under investigation for any reason? (If yes, please explain.)

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.

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FAX NOT ACCEPTABLE

APPENDIX B

ACTIVITY CERTIFICATION

Name of Applicant											
Name of Employer											
Employer Address											
City, State, Zip											
Position/Title of Applicant											
Type of Activity		Medical		Non-Medical		Educational					
Activity Status		Inactive		Active		Volunteer		Other			
Dates of Activity	From:			To:							
Was applicant ever placed on probation, disciplined, placed under investigation, or asked to resign? (If yes, please explain)	☐ Yes ☐ 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)	☐ Yes ☐ No										
Was applicant in good standing during the above stated period of time? (If no, please explain)	☐ Yes ☐ No										
Did applicant take any type of leave of absence or break from this activity? (If yes, please explain)	☐ Yes ☐ No										
Signature of Certifying Official											
Title			Signature Date								
Email address			Telephone No.								

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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)	☐ Yes ☐ 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)	☐ Yes ☐ No						
Was applicant in good standing during the above stated period of time? (If no, please explain)	☐ Yes ☐ No						
Did applicant take any type of leave of absence or break from membership? (If yes, please explain)	☐ Yes ☐ No						
Signature of Certifying Official							
Title		Signature Date					
Email address		Telephone No.					

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FAX NOT ACCEPTABLE **APPENDIX D**

PERPETUAL AUTHORIZATION TO RELEASE INFORMATION

Name of Applicant	

The undersigned applicant for a physician assistant license in the State of Mississippi, hereby authorizes each educational institution at which the undersigned has applied for any license, permit, certificate or registration; each person, firm, corporation, clinic, office, or institution by whom or with whom the undersigned has been employed as a physician assistant; each insurance company with which the undersigned has obtained or made application for medical malpractice liability insurance; each physician or other health care practitioner with whom the undersigned has consulted or seen for diagnosis or treatment; and each professional organization or specialty board to which the undersigned has applied for membership, to disclose and release to the Mississippi State Board of Medical Licensure, 1867 Crane Ridge Drive, Suite 200-B, Jackson, MS 39216, any and all information and documentation concerning the undersigned which the Board deems material for consideration of his/her application. Further, the undersigned hereby consents to the disclosure and release of such information and documentation to the Mississippi State Board of Medical Licensure and waives any privilege or right of confidentiality which the undersigned would otherwise possess with respect thereto.

The undersigned hereby authorizes any person, firm, corporation, clinic, office, institution, state or federal agency from whom the Mississippi State Board of Medical Licensure has requested information to rely on a copy of this release, the original now on file in the office of the Mississippi State Board of Medical Licensure at the above noted address.

The undersigned also agrees to execute any other release or authorization, the execution of which may be required under federal or state law prior to release of any of the documents or information requested. Otherwise, this authorization shall constitute a complete and perpetual release and authorization for all purposes set forth therein.

Signature of Applicant			
Printed Name of Applicant		Signature Date	

Sworn to and subscribed to before me this the _____ day of _____, 20___.

My Commission Expires:	_____ Notary Public

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. A fax is not acceptable.