

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

APPLICATION FOR CERTIFICATE TO PRACTICE AS A PHYSICIAN ASSISTANT

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 Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?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 training were you ever on probation, restrictions, suspension, revocation, modification, or otherwise acted against (explain "otherwise" actions)? YES NO
- 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? YES NO
- 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. YES NO
- 18. Have you ever been denied medical malpractice liability insurance? YES NO
- 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? YES NO
- 20. Have you ever been arrested, other than minor traffic citations? YES NO

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 physician assistant 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. BACCALAUREATE/MASTERS DEGREE

List dates/name/address of the school(s) where Baccalaureate and/or Masters degree was received. Request copy of education transcript be sent directly to the Mississippi State Board of Medical Licensure.

| | Date | Name of School | Address | City/State |
|----|----------------|----------------|---------|------------|
| 1. | _____ to _____ | _____ | _____ | _____ |
| 2. | _____ to _____ | _____ | _____ | _____ |
| 3. | _____ to _____ | _____ | _____ | _____ |

III. PHYSICIAN ASSISTANT EDUCATION

List dates/name/address of the school(s) where physician assistant education was received. Request copy of education transcript be sent directly to the Mississippi State Board of Medical Licensure.

| | Date | Name of School | City/State | Training Program |
|----|----------------|----------------|------------|------------------|
| 1. | _____ to _____ | _____ | _____ | _____ |
| 2. | _____ to _____ | _____ | _____ | _____ |
| 3. | _____ to _____ | _____ | _____ | _____ |
| 4. | _____ to _____ | _____ | _____ | _____ |
| 5. | _____ to _____ | _____ | _____ | _____ |

IV. ACTIVITIES FOLLOWING PHYSICIAN ASSISTANT EDUCATION

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 as a physician assistant. 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. 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 |
|----------------|-------|-------------|----------------|-------|-------------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

VII. NCCPA EXAMINATION

Date/Result: Pass/Fail.

First NCCPA Examination _____

Current Certification _____

VIII. 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. | _____ | _____ | _____ |

IX. 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: _____