MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

For Every Patient. For Every Provider. For Every Mississippian.

APPENDIX B

POST-GRADUATE / PODITARY TRAINING CERTIFICATION

Name of Physician/Podiatrist:					
Name of Institution:					
Institution Address:					
City:	State:			Zip:	
Program Name:					
Program Type	Internship		Residency	Fellowship	
Program Accredited by	ACGME	AOA	APMA	CPME	Not Accredited	Other
Dates of Attendance	From:			To:	
Was physician ever placed on probation, disciplined, or placed under investigation, or asked to resign				Yes *	No
**If yes, please explain:*					
Were any limitations or special requirements placed upon the physician because of questions of academic incompetence, disciplinary problems, or any other reasons?				Yes *	No
**If yes, please explain:*					
Did instructors ever file any negative reports on this physician?				Yes *	No
**If yes, please explain:*					
Did physician take any type of leave of absence or break from his/her training				Yes *	No
**If yes, please explain:*					
Signature of Program Director/Chairman					
Title			Signature Date		
Email address			Telephone No.		

INSTRUCTIONS TO INDIVIDUAL COMPLETING THIS FORM:

- Fill in all spaces. Enter N/A if needed. Do not leave blank spaces.
- **Do not return to applicant**. MSBML is a primary source agency. Submit directly to the Board
- Return by mail to the address below or email a PDF only format to certification@msbml.ms.gov
- Subject line **must** be in this format to ensure a smoother process: License Type + Applicant's Full Name
- Original documents only. **A fax will not be accepted.**

Kenneth Cleveland, M.D. | Executive Director

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