MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

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

APPENDIX C

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 the applicant in good standing during the above stated period?				Yes		No	*
* *If no, please explain:*							
Were any limitations or special requirements placed upon applicant because of questions of incompetence, disciplinary problems, or any other reasons?				Yes	*	No	
* *If yes, please explain:*							
Was the applicant ever placed on probation, disciplined, placed under investigation, or asked to resign?				Yes	*	No	
* *If yes, please explain:*							
Did the applicant take any type of leave of absence or break from this activity?				Yes	*	No	
* *If yes, please explain:*							
Signature of Certifying Official:							
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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