



MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
For Every Patient. For Every Provider. For Every Mississippian.

APPENDIX D

STATE MEDICAL BOARD LICENSURE CERTIFICATION

License Type:	MD/DO	DPM	PA	Other: _____ (print legibly)	
Name of Licensing Board:					
Board Address:					
City:	State:		Zip:		
Name of Applicant:					
Applicant Address:					
City:	State:		Zip:		
License Number:					
Current Status:					
Area of Specialty:					
Type of License:					
Issue Date:					
Expiration Date:					
Licensure Basis	Endorsement	Reciprocity	State Board	NBME	
	FLEX	USMLE	LMCC	Combination	
	NBOME	NCCPA	NBPME	Other	
Has the applicant's license ever been suspended, revoked, or had restrictions imposed?				Yes *	No
* If yes, please explain:					
Is the applicant currently under investigation for any reason?				Yes *	No
* If yes, please explain:					

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.**

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