MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

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

ACUPUNCTURIST MALPRACTICE INSURANCE CERTIFICATION

Name of Applicant:					
Name of Insurance Carrier:					
Name of Insurance Agency:					
Agency Address:	**City:**	**State / Zip:**			
Policy Number:					
Amount of Coverage (Policy Limits): $		**(minimum $1,000,000 in coverage)**			
Dates of Coverage	**From:**	**To:**			
Have any specific procedures been excluded from this coverage?			**Yes** ☐	*	**No** ☐
** If yes, please explain:*					
Are there any current pending judgments or settlements on behalf of this provider?			**Yes** ☐	*	**No** ☐
** If yes, please explain:*					
Have there been any paid judgments or settlements on behalf of this provider?			**Yes** ☐	*	**No** ☐
** If yes, please explain:*					
Have any professional liability suits been defended for this provider?			**Yes** ☐	*	**No** ☐
** If yes to any of the above, please attach a claims history report and an explanation of the details on a separate sheet.*					
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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