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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