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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