



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

**APPENDIX E**

**STAFF MEMBERSHIP CERTIFICATION**

Name of Applicant:			
Name of Hospital, Clinic or Facility:			
Hospital, Clinic or Facility Address:			
City:	State:	Zip:	
Position/Title of Applicant:			
Type of Membership	Employee	Staff Member	Locum Tenens
	Instructor	Emergency Room	Other
Dates of Membership	From:	To:	
Was applicant in good standing during the above stated period?			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?			No
* If yes, please explain:			
Was applicant ever placed on probation, disciplined, placed under investigation, or asked to resign?			No
* If yes, please explain:			
Did applicant take any type of leave of absence or break from membership?			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](mailto: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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