



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

APPENDIX F

**REQUEST FOR COLLEGE VERIFICATION**  
**FROM THE AMERICAN PODIATRIC MEDICAL ASSOCIATION**

<b><u>TO APPLICANT</u></b>			
Please complete the following information and submit to the *address below with a check or money order in the amount of \$15.00. American Podiatric Medical Association, ATTN: Membership Services Dept., 11400 Rockville Pike, Suite 220, Rockville, MD 20852 <i>*It is the applicant's responsibility to confirm the accuracy of this address; it is provided as a courtesy</i>			
<b>Full Name of DPM</b>			
<b>Professional Mailing Address:</b>			
<b>Place of Birth</b>		<b>Date of Birth</b>	
<b>Podiatric School of Graduation</b>			
<b><u>TO AMERICAN PODIATRIC MEDICAL ASSOCIATION</u></b>			
To obtain a Mississippi Medical License, I _____ must have College Verification from you. Enclosed is a \$15.00 check or money order to cover the processing fee. Please accept this as my request to send a College Verification to the Mississippi State Board of Medical Licensure, 805 S. Wheatley Street, Suite 600, Ridgeland, Mississippi 39157.			
<b>Physician Signature</b>		<b>Date</b>	

**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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[www.msbml.ms.gov](http://www.msbml.ms.gov)