MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

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

APPENDIX F

MD/DO FIFTH PATHWAY CERTIFICATION

Name of Physician:			
Name of Institution:			
Institution Address:		**Country:**	
Institution Name if it has changed:			
Affiliated School:			
Dates of Attendance	From:	To:	
Total Number of Weeks Credit	**Date of Completion**		
Did the Physician Complete the program?	Yes ☐	No * ☐	
* *If no, did the physician withdraw, or was dismissed from the program? (Please explain)*			

Type of Clinical Rotation:	**From**	**To**	**Weeks Credit**
1.)			
2.)			
3.)			
4.)			

Signature of Certifying Official:	
Title:	**Signature Date:**
Email Address:	**Phone 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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