



MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

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

EDUCATION CERTIFICATION

Education Type:	MD/DO	DPM	PA
Name of Applicant:			
Name of Institution:			
Institution Address:			
City:	State:	Zip:	
Country:			
Total Number of Weeks of Education:			
Dates of Attendance	From:	To:	
Type of Degree:		Award Date of Degree:	
Was the applicant ever dropped, suspended, placed on probation, or asked to resign?		Yes *	No
* If yes, please explain:			
Did the applicant attend school for a period other than the normal curriculum, or was he/she required to repeat any education?		Yes *	No
* If yes, please explain:			
Did the applicant take any type of break or leave of absence for any reason during school?		Yes *	No
* If yes, please explain:			
Signature of Certifying Official		School Seal	
Title			
Email Address			
Date of Signature			

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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