MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

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

POST-GRADUATE / PODIATRY TRAINING CERTIFICATION

Name of Physician/Podiatrist:						
Name of Institution:						
Institution Address:						
City:		State:			Zip:	
Program Name:						
Program Type	Internship ☐		Residency ☐		Fellowship ☐	
Program Accredited by	ACGME ☐	AOA ☐	APMA ☐	CPME ☐	Not Accredited ☐	Other ☐
Dates of Attendance		From:			To:	
Was physician ever placed on probation, disciplined, or placed under investigation, or asked to resign					Yes * ☐	No ☐
**If yes, please explain:*						
Were any limitations or special requirements placed upon the physician because of questions of academic incompetence, disciplinary problems, or any other reasons?					Yes * ☐	No ☐
**If yes, please explain:*						
Did instructors ever file any negative reports on this physician?					Yes * ☐	No ☐
**If yes, please explain:*						
Did physician take any type of leave of absence or break from his/her training					Yes * ☐	No ☐
**If yes, please explain:*						
Signature of Program Director/Chairman						
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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