



MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

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

Education Certification

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
- Board policy requires original documents from primary source. **A fax will not be accepted.**

Education Type:	MD/DO ☐	DPM ☐	PA ☐	RA ☐
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 or 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				
Signature Date				

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