



MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

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

Staff Membership 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.**

Name of Applicant:			
Name of Hospital, Clinic or Facility:			
Hospital, Clinic or Facility Address:			
City:	State:	Zip:	
Position/Title of Applicant:			
Type of Membership	Employee ☐	Staff Member ☐	Locum Tenens ☐
	Instructor ☐	Emergency Room ☐	Other ☐
Dates of Membership	From:	To:	
Was the applicant in good standing during the above stated period?			Yes ☐ No * ☐
* If no, please explain:			
Were any limitations or special requirements placed upon the applicant because of questions of incompetence, disciplinary problems, or any other reasons?			Yes * ☐ No ☐
* If yes, please explain:			
Was the applicant ever placed on probation, disciplined, placed under investigation, or asked to resign?			Yes * ☐ No ☐
* If yes, please explain:			
Did the applicant take any type of leave of absence or break from membership?			Yes * ☐ No ☐
* If yes, please explain:			
Signature of Certifying Official			
Title		Signature Date	
Email Address		Telephone No.	

Kenneth Cleveland, M.D. | Executive Director

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