Chapter 04 Temporary Licensure

Temporary Training License for Out-of-State Residents

300 An individual enrolled in an out-of-state postgraduate training program wishing to rotate through an ACGME or AOA approved training program within Mississippi, shall not be required to obtain a restricted temporary license provided the rotation lasts no longer than four (4) weeks. However, the individual must submit the following to the Board:

1. A completed information form which has been supplied by the Board.
2. A letter from the physician's postgraduate training program stating that he or she is going to be participating in a rotation in Mississippi and the duration.
3. A letter from the training program in Mississippi stating the physician will be training with them and the duration.
4. Verification of a current license (limited or training), permit, or letter from the state in which the individual is enrolled in a training program.
5. A licensure fee in the amount of $50.

301 The individual may not participate in the Mississippi training program until a valid training license has been issued. The license will be effective the date the individual is to begin the Mississippi rotation and will become null and void the day the individual completes the rotation.

302 If during the duration of the training, it is determined that the physician may stay longer than four (4) weeks, the temporary training license may be renewed for an additional four (4) weeks. Under no circumstances will the license be renewed after eight (8) weeks. An individual anticipating on rotating through a Mississippi training program for a period longer than eight (8) weeks shall be required to obtain a Restricted Temporary Medical License.

303 The Board reserves the right to deny issuance of a temporary training license as provided herein based on any of the statutory grounds as enumerated in Mississippi Code, Sections 73-25-29 and 73-25-83.

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
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Out-of-State Resident Training License

Name:		Date of Birth:
Mailing Address:	Current Postgraduate Training Location:	
Mississippi Rotation Location:		
Telephone Number:	Email Address:	
Medical School:		Date of Graduation:
Current State of Licensure:	License Number:	Type of License:

1.	Have you ever been convicted of a felony?	☐ Yes ☐ No
2.	Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine?	☐ Yes ☐ No
3.	Have you ever been convicted of any violation of a state or federal law relating to controlled substances?	☐ Yes ☐ No
4.	Are any charges against you for violation of state or federal drug laws currently pending in any court?	☐ Yes ☐ No
5.	Have you ever been denied a state or federal controlled substances certificate or have had such a certificate revoked, restricted, conditioned or curtailed?	☐ Yes ☐ No
6.	Have you ever surrendered a state or federal controlled substance certificate for any reason?	☐ Yes ☐ No
7.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, conditioned, curtailed or voluntarily surrendered under threat of suspension or revocation?	☐ Yes ☐ No
8.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?	☐ Yes ☐ No
9.	Have you ever resigned from the medical staff of any hospital or health care facility while an investigation or disciplinary proceeding was being conducted or pending?	☐ Yes ☐ No
10.	Have you ever been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial?	☐ Yes ☐ No
11.	Are you now, or have you ever used any controlled substances or other drugs having addiction-forming or addiction-sustaining liability to the extent it affects your ability to practice medicine with reasonable skill and safety to patients?	☐ Yes ☐ No
12.	Have you ever prescribed to yourself any controlled substance or other drug having addiction-forming or addiction-sustaining liability, or obtained said medications for your own use and consumption through any sources, other than by prescription or order of a licensed physician?	☐ Yes ☐ No

13.	Are you now, or have you ever consumed alcohol or other intoxicating liquors to the extent it affects your ability to practice medicine with reasonable skill and safety to patients?	☐ Yes ☐ No
14.	If your answer to any one of the three preceding questions is "yes", are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in illegal use of controlled substances or other drugs having addiction-forming or addiction-sustaining liability?	☐ Yes ☐ No
15.	Have you ever been diagnosed as having, or have you ever been treated for, pedophilia, exhibitionism or voyeurism, bipolar disorder, sexual disorder, schizophrenia, paranoia or other psychiatric disorder?	☐ Yes ☐ No
16.	Have you ever had a judgement rendered against you, or action settled relating to the performance of your professional service?	☐ Yes ☐ No
17.	Have you ever been denied medical malpractice liability insurance?	☐ Yes ☐ No
18.	To your knowledge, have you ever been or are you now, the subject of an investigation or disciplinary proceeding by any licensing Board/Agency as of the date of this application?	☐ Yes ☐ No
19.	Have you ever been arrested, other than minor traffic citations?	☐ Yes ☐ No

IF ANY OF THE ABOVE ANSWERS ARE IN THE AFFIRMATIVE, PLEASE EXPLAIN IN DETAIL ON AN ATTACHED SHEET AND PROVIDE THE COMPLETE ADDRESS OF ANY PSYCHIATRIST/PSYCHOLOGIST, STATE BOARD, HOSPITAL, ETC.

I, ____________________________________, certify after being duly sworn, that all of the information supplied in the foregoing application is true and correct to the best of my knowledge. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation of any license to practice medicine granted to me and criminal prosecution to the fullest extent of the law.

I further authorize the release of this application and any information submitted with it or information collected by the Mississippi State Board of Medical Licensure in connection with this application, including derogatory information, to any person or organization having a legitimate need for the information and release the Mississippi State Board of Medical Licensure from all liability for the release of this information.

I further authorize the release of information, including derogatory information, which may be in the possession of other individuals or organizations to the Mississippi State Board of Medical Licensure and release this person or organization from any liability for the release of information.

Date ______________________ ____

Applicant's Signature

County of _________________

State of ____________________

SWORN to and subscribed before me this ________________ day of ____________________________, in the year

of _____________.

(SEAL) ____

Notary Public

My Commission Expires: ____________________________

OFFICE USE ONLY:	**License Number:**	**Issue Date:**
	Expiration Date:	**Date Processed:**