MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

1867 CRANE RIDGE DRIVE, SUITE 200-B
JACKSON, MISSISSIPPI 39216
(601) 987-3079

APPLICATION FOR RESTRICTED TEMPORARY LICENSE

GENERAL INFORMATION

1. NAME IN FULL____
(FIRST) (MIDDLE) (LAST) (DEGREE)

2. OTHER NAMES USED ____

3. ADDRESS____
(STREET OR P O BOX) (CITY) (STATE) (ZIP)

4. PLACE OF BIRTH____________________ DATE OF BIRTH____________
(CITY AND STATE OR COUNTRY) (MM/DD/YY)

5. SOCIAL SECURITY NUMBER ____________________ SEX ____________

6. TELEPHONE (W)____________ (H)____________ FACSIMILE ____________

7. E-MAIL ADDRESS ____

8. U. S. DEA NUMBER ____________________ NPI NUMBER____________________

AFFIDAVIT QUESTIONS

		YES	NO
1.	Have you ever been convicted of a felony?	☐	☐
2.	Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine?	☐	☐
3.	Have you ever been convicted of any violation of a state or federal law relating to controlled substances?	☐	☐
4.	Are any charges against you for violation of state or federal drug laws currently pending in any court?	☐	☐
5.	Have you ever been denied a state or federal controlled substances certificate or have had such a certificate revoked, restricted, conditioned or curtailed?	☐	☐
6.	Have you ever surrendered a state or federal controlled substance certificate for any reason?	☐	☐
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?	☐	☐
8.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?	☐	☐
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?	☐	☐
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medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial?	☐	☐
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?	☐	☐
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?	☐	☐
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?	☐	☐
15.	During any postgraduate training were you ever on probation, restrictions, suspension, revocation, modification, or otherwise acted against (explain "otherwise" actions)?	☐	☐
16.	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?	☐	☐
17.	Have you ever had a malpractice claim made or suit filed against you pertaining to any aspect of your medical practice, regardless of whether or not such a claim was dismissed, never pursued, settled, resulted in a favorable or adverse judgment, or is now pending? Please use separate sheet to address each claim or suit.	☐	☐
18.	Have you ever been denied medical malpractice liability insurance?	☐	☐
19.	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?	☐	☐
20.	Have you ever been arrested, other than minor traffic citations?	☐	☐

IF ANY OF THE ABOVE ANSWERS ARE IN THE AFFIRMATIVE, PLEASE EXPLAIN IN DETAIL ON AN ATTACHED SHEET.

21. Have you ever applied for, or been denied a Mississippi medical license? ____________________

22. Have you ever served in the US Military? ________ Branch ______________ Dates______________

23. Do you currently have an anticipated date to begin practice in Mississippi? ________ Date__________

I. RESIDENCY TRAINING PROGRAM

List name and address of residency program in which you will be training.

	Program Name	Institution	City, State, Zip
1.			
2.			
3.			

II. MEDICAL EDUCATION

List all medical schools attended, dates and complete addresses of institutions. Do not list internship and/or residency training.

Date	Name	Address	City/State
1. ______ to______			
2. ______ to______			
3. ______ to______			

III. INTERNSHIP, RESIDENCY AND/OR FELLOWSHIP TRAINING

(Do not list practice experience)

List in chronological order all internship, residency, and/or fellowship training since graduation from medical school with dates and complete addresses of institutions. Specify training program, i.e., Family Practice, OB/GYN, etc.

Date	Hospital/Institution	City/State	Training Program
1. ______ to______			
2. ______ to______			
3. ______ to______			
4. ______ to______			
5. ______ to______			

IV. ACTIVITIES FOLLOWING MEDICAL SCHOOL

List all activities in chronological order since completion of medical school giving dates, institutions/hospitals, and complete addresses. All activities following medical school must be accounted for. Use separate sheet if necessary.

	Date	Place	Address	City/State
1.	______ to ______	______	______	______
2.	______ to ______	______	______	______
3.	______ to ______	______	______	______
4.	______ to ______	______	______	______
5.	______ to ______	______	______	______

V. HOSPITAL PRIVILEGES

List all hospitals in chronological order where you have held staff privileges of any type. Post-graduate training sites should not be listed. Use a separate sheet if necessary.

	Date	Place	Address	City/State
1.	______ to ______	______	______	______
2.	______ to ______	______	______	______
3.	______ to ______	______	______	______
4.	______ to ______	______	______	______
5.	______ to ______	______	______	______

VI. STATE LICENSURE

List all states where you have been licensed to practice medicine or have applied for a license to practice medicine. Include active and/or expired, limited, restricted, temporary, educational or training licenses. Use a separate sheet if necessary.

License Number	State	Year Issued	License Number	State	Year Issued
______	______	______	______	______	______
______	______	______	______	______	______
______	______	______	______	______	______
______	______	______	______	______	______

VII. LICENSING EXAMINATION

1. List date and score of licensing examination taken: (If dates and scores are unknown, indicate which examination was taken).

	Date	Score
USMLE		
Step I	______	______
Step II CK	______	______
Step II CS	______	______
Step III	______	______
National Board of Osteopathic Medical Examiners		
Part I	______	______
Part II CE	______	______
Part II PE	______	______
Part III	______	______
LMCC	______	______

If applicable, ECFMG #______________________ Date Issued______________________

AFFIDAVIT AND PERPETUAL RELEASE OF INFORMATION

I, _______________________________, certify after being duly sworn, that all of the information supplied in the Mississippi State Board of Medical Licensure's restricted temporary license application is true and correct to the best of my knowledge, that the photograph submitted herein is a true likeness of myself and was taken within sixty (60) days prior to the date of this release. I acknowledge that any false or untrue statement or representation made in the restricted temporary license application may result in the denial of initial licensure or 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 the restricted temporary license application and any information submitted with it or information collected by the Mississippi State Board of Medical Licensure in connection with the restricted temporary license 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.

I further authorize each educational institution at which I have applied for any license, permit, certificate or registration; each person, firm, corporation, clinic, office, or institution by whom or with whom I have been employed in the practice of medicine; any hospital at which I have or have had membership; each insurance company with which I have obtained or made application for medical malpractice liability insurance; each physician or other health care practitioner with whom I have consulted or seen for diagnosis or treatment; and each professional organization or specialty board to which I have applied for membership, to disclose and release to the Mississippi State Board of Medical Licensure, 1867 Crane Ridge Drive, Suite 200-B, Jackson, MS 39216, any and all information and documentation concerning me which the Board deems material for consideration of my application. Further, I hereby consent to the disclosure and release of such information and documentation to the Mississippi State Board of Medical Licensure and waive any privilege or right of confidentiality which I would otherwise possess with respect thereto.

I further authorize any person, firm, corporation, clinic, office, institution, state or federal agency from whom the Mississippi State Board of Medical Licensure has requested information to rely on a copy of this release, the original now on file in the office of the Mississippi State Board of Medical Licensure at the above noted address.

I also agree to execute any other release or authorization, the execution of which may be required under federal or state law prior to release of any of the documents or information requested. Otherwise, this authorization shall constitute and operate as a perpetual authorization by me for all purposes set forth therein.

Date ____________________

____
Applicant's Signature

County of ________________

State of ________________

SWORN to and subscribed before me this ____________ day of ________________________, in the year of ____________.

____
Notary Public

My Commission Expires:___________________

(SEAL)

Attach a Passport-Type

Photograph

Taken Within 60 Days.

Informal Snapshots Will Not Be Accepted.

Complete and Submit to:
Mississippi State Board of Medical Licensure
1867 Crane Ridge Drive, Suite 200-B
Jackson, MS 39216