

Pursuant to Section 73-25-23, Mississippi Code, a limited institutional license is available only to graduates of foreign medical schools who are employed or are being considered for employment to practice medicine in one or more Mississippi state-supported institutions located in the same county.

It is understood that graduates of foreign medical schools holding a limited institutional license, and who are employed by and enrolled in an approved ACGME or AOA postgraduate training program at the University of Mississippi Medical Center, shall be authorized to participate in any postgraduate educational program at the University of Mississippi Medical Center, or any of its affiliated training program sites.

An application for limited institutional licensure may be obtained only upon the written request of the director of the state-supported institution which has employed or is considering employing a graduate of a foreign medical school to practice medicine.

A limited institutional license may be issued for a period of one (1) year for practice in a particular institution after a review and favorable recommendations by a majority of the following:

1. President or Secretary, Board of Trustees of Institution
2. Director of Institution
3. President or Secretary, Local Chartered Medical Society in area in which institution is located
4. Member, Board of Trustees, Mississippi State Medical Association in area in which institution is located
5. Member, Mississippi State Board of Medical Licensure from district in which institution is located
6. Executive Officer, Mississippi State Board of Medical Licensure

In addition to the above requirements for a limited institutional license, an applicant shall meet the following requirements:

1. Must be at least twenty-one (21) years of age and of good moral character.
2. Must present original diploma from a reputable medical college or reputable college of osteopathic medicine.
3. Must submit certified copy of valid certificate from the ECFMG or its successor.
4. Must have favorable references from two (2) physicians licensed in the United States with whom the applicant has worked or trained.
5. Must submit an application completed in every detail with recent passport type photograph.
6. Must submit \$250.00 licensure fee.
7. Must appear for a personal interview in the office of the Mississippi State Board of Medical Licensure; successfully pass the Jurisprudence Examination as administered by the Board; and submit to a criminal background check.

The limited institutional licenses of graduates of foreign medical schools so licensed and employed by a state institution shall be renewable annually based upon the favorable recommendation of the director of the institution by which the licensee is employed. A graduate of a foreign medical school so licensed may hold such limited institutional license no longer than five years. The renewal fee is \$100.00 per year.

(A) **Questions 1-27.** Questions 1-27 must be completed by the applicant. Please either type or print this page. If there is an affirmative answer for questions 7-27, a detailed explanation must be attached.

(B) **Section I.** Applicant must list medical education and give dates and complete addresses of institutions.

(C) **Section II.** Applicant must list all training undertaken since graduation from medical school and give dates and complete addresses of institutions. Specify specialty program, i.e. family practice, OB/GYN, anesthesiology, etc.

(D) **Section III.** Applicant must account for all time since graduation from medical school. All activities following medical school and training must be accounted for. The intentional failure to disclose any time period shall constitute falsification which is grounds for denial of the application.

(E) **Section IV.** Applicant must list all states where licensed to practice medicine. Include temporary, limited, restricted, revoked, active and inactive licenses.

(F) **Section V.** Applicant must list dates and scores of licensing examination taken. If dates and scores are unknown, indicate which examination was taken. Questions 1-4 of Section V must be answered. All incomplete applications will be returned.

(G) **Affidavit and Perpetual Release of Information.** Applicant shall read carefully the oath of the truthfulness of information supplied in this application and the release which gives consent to release information to and from the Board. Applicant shall execute the application and have notarized (see enclosed Notary Guide).

(H) **Photograph.** Applicant must attach a photograph taken within the last sixty (60) days of the date of application. This should be a wallet-size, passport-type photograph attached to the application. Informal snapshots, colored paper photos or computer generated photos will not be accepted. All applications not meeting the photo requirement will be returned.

(I) **Recommendation.** Sections I-IV must be completed by the designated individuals. APPLICANT DOES NOT COMPLETE THIS SECTION. The employing institution should have sections I-III completed. Section IV will be completed by the Mississippi State Board of Medical Licensure.

(J) **Birth Certificate.** Applicant shall submit a certified copy or notarized (see Notary Guide) copy of original birth certificate or passport. In the event the name of the applicant differs from the name reflected on the applicant's birth certificate or other certification, the applicant shall submit evidence satisfactory to the Board that establishes the true identity of the applicant (certified copy of legal name change, marriage certificate, divorce decree, etc.)

(K) **Driver's License.** Applicant shall submit a copy of current driver's license.

(L) **Medical School Diploma.** Applicant shall submit a copy of original medical school diploma.

(M) Any document required to be submitted to the Board by an applicant which is not in the English language must be accompanied by a certified translation thereof into English.

Duplicate as many copies of each appendix as you need.

(N) **Appendix A.** Applicant shall send this form to each medical school attended and request the medical school to forward the completed form to the Board. This form will be accepted only if sent directly from the medical school to the Board. Do not have the school send this form back to you.

(O) **Appendix B.** If applicable, applicant shall send this form to the institution where applicant completed internship, residency and/or fellowship and request the institution to forward the completed form to the Board. This form will be accepted only if sent directly from the institution to the Board. Do not have the institution send this form back to you.

(P) **Appendix C.** Applicant must account for all time since graduation from medical school. All activities following medical school and training must be accounted for. Each activity must be verified by the institution. Applicant shall send this form to the institution where activities were performed. This form will be accepted only if sent directly from the institution to the Board. Do not have the institution send this form back to you.

(Q) **Appendix D.** Applicant must complete top portion and forward one to each state in which applicant holds or has held a license to practice medicine. Include temporary, limited, restricted, revoked, active and inactive licenses. This form will be accepted only if sent directly from the state board to the Mississippi Board. Do not have the state board send this form back to you.

(R) **Examination and Board Action History Report.** If applicant took the FLEX, SPEX, or USMLE, applicant must request a transcript from the Federation of State Medical Boards at <http://www.fsmb.org/transcripts.html>.

(S) **ECFMG Verification.** If applicant is a graduate of an international medical school, applicant must request a status report from the ECFMG at <https://cvsonline2.ecfm.org/>.

(T) **Military Records.** If applicant has ever served in any branch of the military, applicant must request a DD Form 214 or its equivalent at <http://www.archives.gov/veterans/military-service-records/get-service-records.html>.

(U) **Application Fees.** Applicant must submit check or money order made payable to the MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE in the amount of \$250.00.

NO FOREIGN CHECKS OR MONEY ORDERS WILL BE ACCEPTED. A \$50.00 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS.

NOTE*** INFORMATION PERTAINING TO APPLICATION OF MEDICAL LICENSE IS GIVEN TO THE APPLICANT ONLY. PLEASE DO NOT ALLOW OTHERS TO CONTACT THIS AGENCY ON YOUR BEHALF. POWER OF ATTORNEY WILL NOT BE ACCEPTED.

MEMORANDUMS CONTAINING DOCUMENTS MISSING FROM APPLICANT'S FILE WILL BE MAILED OUT WEEKLY.

IMPORTANT

Upon submission of an application for licensure to the Board, the applicant shall promptly provide all information deemed necessary by the Board to process the application, including, but not limited to letters of recommendation, certification of graduation from medical school, photograph of applicant, internship certificate and birth certificate. The Board shall have a reasonable period of time within which to collect and assimilate all required documents and information necessary to issue a medical license. If, after submitting an application for medical license, an applicant has failed to respond or make a good faith effort to pursue licensure for a period of three (3) months, the application will be considered null and void, and applicant will have to reapply for licensure, including, but not limited to, all fees, application, certifications, and references. Additionally, if after one year from the date of receipt of application, applicant has not received a medical license, the application will be considered null and void, and applicant will have to reapply for licensure, including, but not limited to, all fees, application, certifications, and references. Under no circumstances will the one year time limit be waived.

When having your application, birth certificate, passport, or any other documents notarized, please use the following checklist as a guide to ensure proper notarization.

All documents require the following:

1. Notary's stamp or seal
2. Notary's name
3. Notary's signature
4. Notary's commission expiration date
5. Date of notarization (must be original and dated within the last six (6) months)

Documents which must be certified require the notary to certify that the document is a "true & correct copy of the original." If the notary will not certify the document, you may attest that it is a "true & correct copy of the original" and sign the statement. The notary may then notarize your signature.

The notary may attach an affidavit, or cover sheet, if he/she chooses. Some states require an affidavit be used instead of notarizing the actual document. Affidavits must also meet the above checklist requirements and be attached to the document.

If your document is not in English, it must be translated into English. This translation must also be notarized as outlined above. The translation and the original language document must both be notarized and submitted.

Please submit only photocopies of your documents. DO NOT SUBMIT ORIGINAL DOCUMENTS.

Photocopies of the notarization will **NOT** be accepted.

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 (601) 987-3079
 WWW.MSBML.MS.GOV

FAX NOT ACCEPTABLE

APPENDIX A

MEDICAL/OSTEOPATHIC SCHOOL CERTIFICATION

Name of Physician			
Name of Institution			
Institution Address			
City, State, Zip			
Country			
Total number of weeks of medical education			
Dates of Attendance		From:	To:
Type of Degree		Award Date of Degree	
Was physician ever dropped, suspended, placed on probation, or asked to resign? (If yes, please explain)			<input type="checkbox"/> Yes <input type="checkbox"/> No
Did the physician attend medical/osteopathic school for a period other than the normal curriculum, or was he/she required to repeat any medical education? (If yes, please explain)			<input type="checkbox"/> Yes <input type="checkbox"/> No
Did physician take any type of break or leave of absence for any reason during medical/osteopathic school? (If yes, please explain)			<input type="checkbox"/> Yes <input type="checkbox"/> No
Signature of certifying official		School Seal	
Title			
Email address			
Date of signature			

INSTRUCTIONS TO INDIVIDUAL COMPLETING THIS FORM:

Please fill in all applicable spaces and return to the Mississippi State Board of Medical Licensure at the above address or email a PDF format to certification@msbml.ms.gov. International medical schools must return via mail, emails are not acceptable. Do not send this certification back to the applicant as the Board will not consider the certification unless it is received directly from the institution. Board policy requires original documents from primary source. A fax is not acceptable.

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APPENDIX B

POST-GRADUATE TRAINING CERTIFICATION

Name of Physician			
Name of Institution			
Institution Address			
City, State, Zip			
Internship, Residency, Fellowship Program Name			
Program Accredited by	<input type="checkbox"/> ACGME	<input type="checkbox"/> AOA	<input type="checkbox"/> Not Accredited
Dates of Attendance	From:	To:	
Was physician ever placed on probation, disciplined or placed under investigation, or asked to resign? (If yes, please explain)	<input type="checkbox"/> Yes		<input type="checkbox"/> No
Were any limitations or special requirements placed upon physician because of questions of academic incompetence, disciplinary problems or any other reasons? (If yes, please explain)	<input type="checkbox"/> Yes		<input type="checkbox"/> No
Did instructors ever file any negative reports on this physician? (If yes, please explain)	<input type="checkbox"/> Yes		<input type="checkbox"/> No
Did physician take any type of leave of absence or break from his/her training? (If yes, please explain)	<input type="checkbox"/> Yes		<input type="checkbox"/> No
Signature of Program Director/Chairman			
Title		Signature Date	
Email address		Telephone No.	

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APPENDIX C

ACTIVITY CERTIFICATION

Name of Applicant								
Name of Employer								
Employer Address								
City, State, Zip								
Position/Title of Applicant								
Type of Activity		Medical		Non-Medical		Educational		
Activity Status		Inactive		Active		Volunteer		Other
Dates of Activity	From:			To:				
Was applicant ever placed on probation, disciplined, placed under investigation, or asked to resign? (If yes, please explain)							<input type="checkbox"/> Yes	
							<input type="checkbox"/> No	
Were any limitations or special requirements placed upon applicant because of questions of incompetence, disciplinary problems or any other reasons? (If yes, please explain)							<input type="checkbox"/> Yes	
							<input type="checkbox"/> No	
Was applicant in good standing during the above stated period of time? (If no, please explain)							<input type="checkbox"/> Yes	
							<input type="checkbox"/> No	
Did applicant take any type of leave of absence or break from this activity? (If yes, please explain)							<input type="checkbox"/> Yes	
							<input type="checkbox"/> No	
Signature of Certifying Official								
Title				Signature Date				
Email address				Telephone No.				

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APPENDIX D

STATE MEDICAL BOARD LICENSURE CERTIFICATION

Name of State Medical Board	
State Medical Board Address	
City, State, Zip	

Name of Applicant	
Applicant Address	
City, State, Zip	

Medical License #		Current Status	
Area of Specialty		Type of License	
Issue Date		Expiration Date	

Licensure Base		Endorsement		Reciprocity		State Board
		NBME		FLEX		USMLE
		LMCC		Combination		NBOME

Has applicant's license ever been suspended, revoked or had restrictions imposed? (If yes, please attach documents.)
Is applicant currently under investigation for any reason? (If yes, please explain.)

Signature of Certifying Official			
Title		Signature Date	
Email address		Telephone No.	

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