MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
CYPRESS RIDGE BUILDING • 1867 CRANE RIDGE DRIVE, SUITE 200-B • JACKSON, MS 39216
(601) 987-3079
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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)			☐ Yes ☐ 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)			☐ Yes ☐ No
Did physician take any type of break or leave of absence for any reason during medical/osteopathic school? (If yes, please explain)			☐ Yes ☐ 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.