MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
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(601) 987-3079
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FAX NOT ACCEPTABLE

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	☐	ACGME	☐	AOA	☐	Not Accredited	☐	Other
Dates of Attendance	From:			To:				

Was physician ever placed on probation, disciplined, or placed under investigation, or asked to resign? (If yes, please explain)	☐ Yes ☐ 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)	☐ Yes ☐ No
Did instructors ever file any negative reports on this physician? (If yes, please explain)	☐ Yes ☐ No
Did physician take any type of leave of absence or break from his/her training? (If yes, please explain)	☐ Yes ☐ No

Signature of Program Director/Chairman			
Title		Signature Date	
Email address		Telephone No.	

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. 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.