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 F

FIFTH PATHWAY CERTIFICATION

Name of Physician			
Name of Institution			
Institution Address w/ Country			
Institution Name if it has changed			
Affiliated School			
Dates of Attendance	From:	To:	
Total Number of Weeks Credit		Date of Completion	
Did the Physician Complete the program?	☐ Yes	☐ No	
If no, did the physician withdraw, or was dismissed from the program? (Please explain)			

Type of Clinical Rotation:	From	To	Weeks Credit
1.)			
2.)			
3.)			
4.)			

Signature of Certifying Official			
Title		Signature Date	
Email Address		Phone 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.