

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 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)							<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.				

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.