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 C

STAFF MEMBERSHIP CERTIFICATION

Name of Applicant							
Name of Hospital, Clinic or Facility							
Hospital, Clinic or Facility Address							
City, State, Zip							
Position/Title of Applicant							
Type of Membership	☐	Employee	☐	Staff Member	☐	Locum Tenens	
	☐	Instructor	☐	Emergency Room	☐	Other	
Dates of Membership	From:		To:				
Was applicant in good standing during the above stated period? (If no, please explain)	☐ Yes ☐ 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)	☐ Yes ☐ No						
Was applicant ever placed on probation, disciplined, placed under investigation, or asked to resign? (If yes, please explain)	☐ Yes ☐ No						
Did applicant take any type of leave of absence or break from membership? (If yes, please explain)	☐ Yes ☐ No						
Signature of Certifying Official							
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.