MISSISSIPPI STATE BOARD
OF MEDICAL LICENSURE
1867 CRANE RIDGE DRIVE, SUITE 200-B
JACKSON, MISSISSIPPI 39216
(601) 987-3079

For Office Use Only
Check #_____
Amount_____
Application #_____

APPLICATION FOR REINSTATEMENT OF LICENSE TO PRACTICE AS A PHYSICIAN ASSISTANT

Type or Print Legibly

Personal Information

Fields in **bold** are required information.

Last Name	**First Name**	Middle Name	**Degree**
Alternate Names *(if any)*			
***Address (Street or P O Box)**			
City		**State**	**Zip**

Place of Birth (City & State or Country)	**Date of Birth (Month/Day/Year)**	
Social Security Number	**Gender**	
U.S. DEA Number	NPI Number	
Work Phone	Facsimile	**Home Phone**
Email Address		
Physician Assistant School		**Date of Graduation**
Mississippi License Number	**Expiration Date**	**Issue Date**

***The Board will use this address for all correspondence.**

Affidavit Questions

Answer questions by circling "Yes" or "No". If any of the following answers are in the affirmative, explain in detail on a separate sheet.

1.	Have you ever been convicted of a felony?	Yes No
2.	Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice as a physician assistant?	Yes No
3.	Have you ever been convicted of any violation of a state or federal law relating to controlled substances?	Yes No
4.	Are any charges against you for violation of state or federal drug laws currently pending in any court?	Yes No

5.	Have you ever been denied a state or federal controlled substances certificate or have had such a certificate revoked, restricted, conditioned or curtailed?	Yes No
6.	Have you ever surrendered a state or federal controlled substance certificate for any reason?	Yes No
7.	Has your certificate of qualification or license to practice as a physician assistant in any state been suspended, revoked, restricted, conditioned, curtailed or voluntarily surrendered under threat of suspension or revocation?	Yes No
8.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?	Yes No
9.	Have you ever resigned from the medical staff of any hospital or health care facility while an investigation or disciplinary proceeding was being conducted or pending?	Yes No
10.	Have you ever been denied a certificate of qualification or license to practice as a physician assistant in any state, or has your application for a certificate of qualification or license to practice as a physician assistant been withdrawn under threat of denial?	Yes No
11.	Are you now, or have you ever used any controlled substances or other drugs having addiction-forming or addiction-sustaining liability to the extent it affects your ability to practice as a physician assistant with reasonable skill and safety to patients?	Yes No
12.	Have you ever prescribed to yourself any controlled substance or other drug having addiction-forming or addiction-sustaining liability, or obtained said medications for your own use and consumption through any sources, other than by prescription or order of a licensed physician or other healthcare provider authorized to prescribe?	Yes No
13.	Are you now, or have you ever consumed alcohol or other intoxicating liquors to the extent it affects your ability to practice as a physician assistant with reasonable skill and safety to patients?	Yes No
14.	If your answer to any one of the three preceding questions is "yes", are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in illegal use of controlled substances or other drugs having addiction-forming or addiction-sustaining liability?	Yes No
15.	Have you ever been diagnosed as having, or have you ever been treated for, pedophilia, exhibitionism, or voyeurism, bipolar disorder, sexual disorder, schizophrenia, paranoia or other psychiatric disorder?	Yes No
16.	Have you ever had a malpractice claim made or suit filed against you pertaining to any aspect of your medical practice, regardless of whether or not such a claim was dismissed, never pursued, settled, resulted in a favorable or adverse judgment, or is now pending? Use separate sheet to address each claim or suit.	Yes No
17.	Have you ever been denied medical malpractice liability insurance?	Yes No
18.	To your knowledge you ever been or are you now, the subject of an investigation or disciplinary proceeding by any licensing Board/Agency as of the date of this application?	Yes No
19.	Have you ever been arrested, other than minor traffic citations?	Yes No
20.	Have you ever served in the US Military? If yes, Branch_____ Dates_____	Yes No

Any investigation during the application process must be reported to the Board immediately.

Practice Names and Practice Locations

List name as appears at each current practice location-Solo, Group, Hospital, etc.

Primary Practice	Address	City/State/Zip
Intended Practice	**Address**	**City/State/Zip**
Additional Practice	**Address**	**City/State/Zip**

Activities Following Medical School and Training

List **in chronological order** all practice experience since issuance of MS physician assistant license. If any period did not include practice experience, give explanation. **All** activities **must** be accounted for. Use separate sheet if necessary.

Date (From/To)	Activity	Address	City/State/Zip
1. _____/_____			
2. _____/_____			
3. _____/_____			
4. _____/_____			
5. _____/_____			
6. _____/_____			
7. _____/_____			
8. _____/_____			

Hospital Privileges

List **in chronological order** all hospitals where you have held staff privileges of any type since issuance of MS physician assistant license. Use separate sheet if necessary

Date (From/To)	Name	Address	City/State/Zip
1. _____/_____			
2. _____/_____			
3. _____/_____			
4. _____/_____			
5. _____/_____			
6. _____/_____			
7. _____/_____			
8. _____/_____			
9. _____/_____			
10. _____/_____			
11. _____/_____			
12. _____/_____			

State Licensure

List **ALL** states where you have been licensed to practice as a physician assistant or have applied for a license to practice as a physician assistant. Include active and/or expired, limited, restricted, temporary, educational or training licenses. Use a separate sheet if necessary.

License Number	State	Year Issued	License Number	State	Year Issued

Affidavit and Release

I, _____, certify after being duly sworn, that all of the information supplied in the foregoing application is true and correct to the best of my knowledge, that the photograph submitted herein is a true likeness of myself and was taken within sixty (60) days prior to the date of this application. I acknowledge that any false or untrue statement or representation made in this application may result in the revocation of any license to practice as a physician assistant granted to me and criminal prosecution to the fullest extent of the law.

I further authorize the release of this application and any information submitted with it or information collected by the Mississippi State Board of Medical Licensure in connection with this application, including derogatory information, to any person or organization having a legitimate need for the information and release the Mississippi State Board of Medical Licensure from all liability for the release of this information.

I further authorize the release of information, including derogatory information, which may be in the possession of other individuals or organizations to the Mississippi State Board of Medical Licensure and release this person or organization from any liability for the release of information.

Date _____ _____

Applicant's Signature

County of _____

State of _____

SWORN to and subscribed before me this _____ day of _____, in the year of _____.

PHOTOGRAPH

(wallet-size, passport-type)

TAKEN WITHIN

SIXTY (60) DAYS

must be attached here with

tape. Do not paste.

COMPUTER GENERATED OR

INFORMAL SNAPSHOTS

WILL NOT BE ACCEPTED

_____

Notary Public

My Commission Expires: _____

(SEAL)

FOR USE OF MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE ONLY

INVESTIGATOR INTERVIEWER: _____

DATE OF INTERVIEW: _____