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

APPLICATION FOR SPECIAL VOLUNTEER LICENSE

1. NAME IN FULL____
(FIRST) (MIDDLE) (LAST) (DEGREE)

2. ADDRESS____
(STREET OR P O BOX) (CITY) (STATE) (ZIP)

3. PLACE OF BIRTH______________________ DATE OF BIRTH__________
(CITY AND STATE OR COUNTRY) (MM/DD/YYYY)

4. SOCIAL SECURITY # ______________________ GENDER__________

5. TELEPHONE (W)__________ (H)__________ FACSIMILE __________

6. EMAIL ADDRESS____

		YES	NO
7.	Have you ever been convicted of a felony?	______	______
8.	Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine?	______	______
9.	Have you ever been convicted of any violation of a state or federal law relating to controlled substances?	______	______
10.	Are any charges against you for violation of state or federal drug laws currently pending in any court?	______	______
11.	Have you ever been denied a state or federal controlled substances certificate or have had such a certificate revoked, restricted, conditioned or curtailed?	______	______
12.	Have you ever surrendered a state or federal controlled substance certificate for any reason?	______	______
13.	Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, conditioned, curtailed or voluntarily surrendered under threat of suspension or revocation?	______	______
14.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?	______	______
15.	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
16.	Have you ever been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial?	________	________
17.	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 medicine with reasonable skill and safety to patients?	________	________
18.	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?	________	________
19.	Are you now, or have you ever consumed alcohol or other intoxicating liquors to the extent it affects your ability to practice medicine with reasonable skill and safety to patients?	________	________
20.	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?	________	________
21.	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?	________	________
22.	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? Please use separate sheet to address each claim or suit.	________	________
23.	Have you ever been denied medical malpractice liability insurance?	________	________
24.	To your knowledge, have 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?	________	________
25.	Have you ever been arrested, other than minor traffic citations?	________	________

IF ANY OF THE ABOVE ANSWERS ARE IN THE AFFIRMATIVE, PLEASE EXPLAIN IN DETAIL ON AN ATTACHED SHEET AND PROVIDE THE COMPLETE ADDRESS OF ANY PSYCHIATRIST/PSYCHOLOGIST, STATE BOARD, HOSPITAL, ETC.

I. MEDICAL EDUCATION

List all medical schools attended, dates and complete addresses of institutions. Do not list internship and/or residency training.

		Name of School	City/State
1.	From_______ to______	____________________________	____________________________
2.	From_______ to_______	____________________________	____________________________

II. ACTIVITIES FOLLOWING MEDICAL SCHOOL AND TRAINING

List all activities since completion of medical school, giving dates and complete addresses. If any period did not include practice experience, give explanation. All activities following medical school must be accounted for. Use separate sheet if necessary.

		Place	Address
1.	From ______ to_______	____________________________	____________________________
			____________________________
2.	From ______ to_______	____________________________	____________________________
			____________________________
3.	From ______ to_______	____________________________	____________________________
			____________________________

III. STATE LICENSURE

List all states where you have been licensed to practice medicine or have applied for a license to practice medicine. It is a requirement that each state complete one of the verification forms included with your application.

License Number	State	Year Issued	License Number	State	Year Issued
__________	__________	__________	__________	__________	__________
__________	__________	__________	__________	__________	__________

PHOTOGRAPH
(wallet-size, passport-type)

TAKEN WITHIN
SIXTY (60) DAYS

must be attached here with

tape. Do not paste.

INFORMAL SNAPSHOT

WILL NOT BE ACCEPTED

IV. 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 medicine 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.

I further acknowledge that my practice under the special volunteer medical license will be exclusively and totally devoted to providing medical care to needy and indigent persons in Mississippi or persons in medically underserved areas in Mississippi.

I further acknowledge that I will not receive any payment or compensation, either direct or indirect, or have the expectation of any payment or compensation, for any medical services rendered under the special volunteer medical license.

Date __________________________

____
Applicant's Signature

County of ____________________

State of _______________________

SWORN to and subscribed before me this _________________ day of _________________________, in the year

of _______________.

(SEAL)

____
Notary Public

My Commission Expires: ______________________________________

FOR USE OF MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE ONLY

SPECIAL VOLUNTEER LICENSE NUMBER:___________________

ISSUED ON:____

WALL CERTIFICATE MAILED:______________________________