IMPORTANT

Upon submission of an application for licensure to the Board, the applicant shall promptly provide all information deemed necessary by the Board to process the application, including, but not limited to certification of graduation from medical school, photograph of applicant, internship certificate and birth certificate. The Board shall have a reasonable period of time within which to collect and assimilate all required documents and information necessary to issue a medical license. If, after submitting an application for medical license, an applicant has failed to respond or make a good faith effort to pursue licensure for a period of three (3) months, the application will be considered null and void, and applicant will have to reapply for licensure, including, but not limited to, all fees, application, certifications, and references. Additionally, if after one year from the date of receipt of application, applicant has not received a medical license, the application will be considered null and void, and applicant will have to reapply for licensure, including, but not limited to, all fees, application, certifications, and references. Under no circumstances will the one year time limit be waived.

Questions regarding applications should be directed to the licensing professionals at the following email addresses. If last name begins with:

A-F: licofficer1@msbml.ms.gov

G-N: licofficer3@msbml.ms.gov

O-Z: licofficer2@msbml.ms.gov

(A) Questions 1-25. Questions 1-25 must be completed by the applicant. Please either type or print this page. If there is an affirmative answer for questions 7-25, please explain in detail on a separate sheet.

(B) Section I. Applicant must list medical education and give dates and addresses.

(C) Section II. Applicant must account for the time since graduation from medical school. The intentional failure to cover any time period shall constitute falsification which is grounds for denial of the application.

(D) Section III. Applicant must list all states where applicant has been licensed or applied for a license whether application was granted or denied, withdrawn or left incomplete.

(E) Photograph. Applicant must attach a photograph taken within the last sixty (60) days of the date of affidavit. This should be a wallet-size, passport-type photograph attached to the application. Informal snapshots, colored paper photos or computer generated photos will not be accepted.

(F) Section IV. Applicant shall read carefully the oath of the truthfulness of information supplied in this section which gives consent to release information to and from the Board. Applicant must sign and notarize (see notary guide) this section.

(G) Foreign Language Documents. Any document required to be submitted to the Board by an applicant which is not in the English language must be accompanied by a certified translation thereof into English by a recognized translator. The Board will accept a notarized (see notary guide) copy of certified translation.

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:_____

Verifications requested by the applicant

Duplicate as many copies of each appendix as you need. Primary source verifications are required. These verifications will be accepted only if sent directly from the institution to the Board. Do not have the institutions send verifications back to the applicant. Board policy requires original documents from primary source. Verifications may be returned to the Board via U.S. Postal Service or email. International medical schools must return via mail; emails from out of the country and faxes are not acceptable.

(A) Appendix A. Applicant shall send this form to each medical school attended and request the medical school to forward the completed form to the Board.

(B) Appendix B. Applicant must account for all time since graduation from medical school. All activities following medical school and training must be accounted for. Each activity must be verified by the institution. Applicant shall send this form to the institution where activities were performed.

(C) Appendix C. Applicant must complete top portion and forward one to each state in which he/she holds or has held a license to practice medicine. Include temporary, limited, restricted, revoked, active and inactive licenses.

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FAX NOT ACCEPTABLE **APPENDIX A**

MEDICAL/OSTEOPATHIC SCHOOL CERTIFICATION

Name of Physician			
Name of Institution			
Institution Address			
City, State, Zip			
Country			
Total number of weeks of medical education			
Dates of Attendance		From:	To:
Type of Degree		Award Date of Degree	
Was physician ever dropped, suspended, placed on probation, or asked to resign? (If yes, please explain)			☐ Yes ☐ No
Did the physician attend medical/osteopathic school for a period other than the normal curriculum, or was he/she required to repeat any medical education? (If yes, please explain)			☐ Yes ☐ No
Did physician take any type of break or leave of absence for any reason during medical/osteopathic school? (If yes, please explain)			☐ Yes ☐ No
Signature of certifying official		School Seal	
Title			
Email address			
Date of signature			

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. International medical schools must return via mail; emails are not acceptable. 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.

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FAX NOT ACCEPTABLE

APPENDIX B

ACTIVITY CERTIFICATION

Name of Applicant											
Name of Employer											
Employer Address											
City, State, Zip											
Position/Title of Applicant											
Type of Activity		Medical		Non-Medical		Educational					
Activity Status		Inactive		Active		Volunteer		Other			
Dates of Activity	From:			To:							

Was applicant ever placed on probation, disciplined, placed under investigation, or asked to resign? (If yes, 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 in good standing during the above stated period of time? (If no, please explain)	☐ Yes ☐ No
Did applicant take any type of leave of absence or break from this activity? (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.

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FAX NOT ACCEPTABLE **APPENDIX C**

STATE MEDICAL BOARD LICENSURE CERTIFICATION

Name of State Medical Board	
State Medical Board Address	
City, State, Zip	

Name of Applicant	
Applicant Address	
City, State, Zip	

Medical License #		Current Status	
Area of Specialty		Type of License	
Issue Date		Expiration Date	

Licensure Base		Endorsement		Reciprocity		State Board
		NBME		FLEX		USMLE
		LMCC		Combination		NBOME

Has applicant's license ever been suspended, revoked or had restrictions imposed? (If yes, please attach documents.)
Is applicant currently under investigation for any reason? (If yes, please explain.)

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.

VOLUNTEER LICENSE ACKNOWLEDGMENT

I, _____, acknowledge that I 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; and

I, _____, 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.

_____
Physician Signature

_____
Date

Sworn to and subscribed in my presence this _____ day of _____, 20_____.

_____
Notary Public

Seal

This form is to be signed, dated, notarized, and returned to the offices of the Mississippi State Board of Medical Licensure before volunteer medical license will be issued.