RESTRICTED TEMPORARY LICENSURE REQUIREMENTS MARCH 2016

Mississippi temporary medical or podiatric licenses may be issued to applicants for licensure in Mississippi under the following conditions:

1. A restricted temporary medical or podiatric license may be issued upon proper completion of an application to an applicant who otherwise meets all requirements for licensure except successful completion:
   a. of the postgraduate training requirements provided below:
      i. If a graduate from a medical college or college of osteopathic medicine in the United States, Canada or Puerto Rico, applicant must present documentation of having completed at least one (1) year of postgraduate training in the United States accredited by the ACGME or by the AOA; or training in Canada accredited by the RCPS.
      ii. If a graduate from a foreign medical school, applicant must present documentation of having completed either:
         (1) three (3) or more years of ACGME-approved postgraduate training in the United States or training in Canada approved by the RCPS; or
         (2) one (1) year of ACGME-approved postgraduate training in the United States or training in Canada approved by the RCPS and be currently board certified by a specialty board recognized by the ABMS; and/or
         (3) of Step 3 of USMLE, Level 3 of COMLEX, or Part 3 of the APMLE.

Such restricted temporary license shall entitle the physician to practice medicine or podiatric medicine only within the confines of an ACGME, AOA or APMA approved postgraduate training program in this state and may be renewed annually for the duration of the postgraduate training for a period not to exceed five (5) years.

In addition to the above requirements for licensure by credentials, an individual shall meet the following requirements:

1. Applicant must be twenty-one (21) years of age and of good moral character.
2. Present a diploma from a reputable medical college or college of osteopathic medicine, subject to the following conditions:
   a. If the degree is from a medical college or a college of osteopathic medicine in the United States or Puerto Rico, the medical college must be accredited at the time of graduation by the LCME, a Joint Committee of the Association of American Medical Colleges (AAMC) and the AMA or the College of Osteopathic Medicine which must be accredited by the AOA.
   b. The degree is from a Canadian medical school, the school must be accredited at the time of graduation by the LCME and by the Committee on Accreditation for Canadian Medical Schools.
   c. If the degree is from a foreign medical school, an applicant must either (i) possess a valid certificate from the ECFMG or (ii) document successful completion of a Fifth Pathway program and be currently board certified by a specialty board recognized by the ABMS. The Board will accept for licensure only those individuals completing Fifth Pathway Programs by December 31, 2009. Credentialing via Fifth Pathway Programs will be considered on an individual basis.
   d. Any diploma or other 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.

Mississippi restricted temporary medical licenses are issued under the condition that the licensee shall not apply to the U.S. Drug Enforcement Administration for a Controlled Substances Registration Certificate.

(A) **General Information.** Lines 1-8 must be either typed or printed.

(B) **Affidavit Questions.** Questions 1-23 must be completed by the applicant. If there is an affirmative answer for questions 1-23, a detailed explanation must be attached.

(C) **Section I.** Applicant must list name and address of residency program in which applicant will be training.

(D) **Section II.** Applicant must list medical education and give dates and complete addresses of institutions.

(E) **Section III.** Applicant must list all training undertaken since graduation from medical school and give dates and complete addresses of institutions. Specify specialty program, i.e. family practice, OB/GYN, anesthesiology, etc.

(F) **Section IV.** Applicant must account for all time since graduation from medical school. All activities following medical school must be accounted for. The intentional failure to disclose any time period shall constitute falsification which is grounds for denial of the application.

(G) **Section V.** Applicant must list all hospitals where applicant has held staff privileges. Post-graduate training sites should not be listed.

(H) **Section VI.** Applicant must list all states where licensed to practice medicine. Include temporary, limited, restricted, revoked, active and inactive licenses.

(I) **Section VII.** Applicant must list dates and scores of licensing examination taken. If dates and scores are unknown, indicate which examination was taken.

(J) **Section VIII.** Applicant shall read carefully the oath of the truthfulness of information supplied in this application and the release which gives consent to release information to and from the Board. Applicant shall execute the application and have notarized (see enclosed Notary Guide).

(K) **Photograph.** Applicant must attach a photograph taken within the last sixty (60) days of the date of application. 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. All applications not meeting the photo requirement will be returned.

(L) **Birth Certificate.** Applicant shall submit a certified copy or notarized (see Notary Guide) copy of original birth certificate or passport. In the event the name of the applicant differs from the name reflected on the applicant's birth certificate or other certification, the applicant shall submit evidence satisfactory to the Board that establishes the true identity of the applicant (certified copy of legal name change, marriage certificate, divorce decree, etc.)

(M) **Medical School Diploma.** Applicant shall submit a copy of original medical school diploma.

(N) 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.

Duplicate as many copies of each appendix as you need.

(O) **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. This form will be accepted only if sent directly from the medical school to the Board. Do not have the school send this form back to you.

(P) **Appendix B.** If applicable, applicant shall send this form to the institution where he/she completed his/her internship, residency and/or fellowship and request the institution to forward the completed form to the Board. This form will be accepted only if sent directly from the institution to the Board. Do not have the institution send this form back to you.

(Q) **Appendix C.** Applicant must account for all time since graduation from medical school. All activities following medical school must be accounted for. Each activity must be verified by the institution. Applicant shall send this form to the institution where activities were performed. This form will be accepted only if sent directly from the institution to the Board. Do not have the institution send this form back to you.

(R) **Appendix D.** Applicant shall make copies from original and forward to each hospital where he/she holds or has held staff privileges. This form will be accepted only if sent directly from the hospital to the Mississippi Board. Do not have the hospital send this form back to you.

(S) **Appendix E.** If applicable, 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. This form will be accepted only if sent directly from the state board to the Mississippi Board. Do not have the state board send this form back to you.

(T) **Examination and Board Action History Report.** If applicant took the FLEX, SPEX, or USMLE, applicant must request a transcript from the Federation of State Medical Boards at **http://www.fsmb.org/transcripts.html**.

(U) **NBME Certification.** If applicant took the NBME, applicant must request a transcript from the National Board of Medical Examiners at **http://www.nbme.org/programs-services/medical-students/certifications-transcripts.html.**

(V) **NBOME Certification.** If applicant took the NB0ME, applicant must request a transcript from the National Board of Osteopathic Medical Examiners at **http://www.nbome.com/**.

(W) **Licentiate of the Medical Council of Canada (LMCC) Certification.** If applicant took the LMCC, applicant must request a statement of registration at **http://www.mcc.ca/english/registration/statements.html**.

(X) **ECFMG Certification.** If applicant has an ECFMG Certificate, applicant must request certification verification from the Educational Commission for Foreign Medical Graduates at **https://cvsonline2.ecfmg.org/.**

(Y) **Military Records.** If applicant has ever served in any branch of the military, applicant must request a DD Form 214 or its equivalent at **http://www.archives.gov/veterans/military-service-records/get-service-records.html.**

(Z) **Application Fees.** Applicant must submit check or money order made payable to the MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE in the amount of $50.00.

NO FOREIGN CHECKS OR MONEY ORDERS WILL BE ACCEPTED. A $50.00 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS.

IMPORTANT

Information pertaining to application of medical license is given to the applicant only. Please do not allow others to contact this agency on your behalf. Power of attorney will not be accepted.

Memorandums containing documents missing from applicant's file will be emailed to the email address submitted on application.

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 certification 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, and certifications. 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, and certifications. Under no circumstances will the one year time limit be waived.

When having your application, birth certificate, passport, or any other documents notarized, please use the following checklist as a guide to ensure proper notarization.

All documents require the following:

1. Notary's stamp or seal
2. Notary's name
3. Notary's signature
4. Notary's commission expiration date
5. Date of notarization (must be original and dated within the last six (6) months)

Documents which must be certified require the notary to certify that the document is a "true & correct copy of the original." If the notary will not certify the document, you may attest that it is a "true & correct copy of the original" and sign the statement. The notary may then notarize your signature.

The notary may attach an affidavit, or cover sheet, if he/she chooses. Some states require an affidavit be used instead of notarizing the actual document. Affidavits must also meet the above checklist requirements and be attached to the document.

If your document is not in English, it must be translated into English. This translation must also be notarized as outlined above. The translation and the original language document must both be notarized and submitted.

Please submit only photocopies of your documents. DO NOT SUBMIT ORIGINAL DOCUMENTS.

Photocopies of the notarization will **NOT** be accepted.

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

1867 CRANE RIDGE DRIVE, SUITE 200-B
JACKSON, MISSISSIPPI 39216
(601) 987-3079

APPLICATION FOR RESTRICTED TEMPORARY LICENSE

GENERAL INFORMATION

1. NAME IN FULL _____
(FIRST) (MIDDLE) (LAST) (DEGREE)

2. OTHER NAMES USED _____

3. ADDRESS _____
(STREET OR P O BOX) (CITY) (STATE) (ZIP)

4. PLACE OF BIRTH _____ DATE OF BIRTH _____
(CITY AND STATE OR COUNTRY) (MM/DD/YY)

5. SOCIAL SECURITY NUMBER _____ SEX _____

6. TELEPHONE (W) _____ (H) _____ FACSIMILE _____

7. E-MAIL ADDRESS _____

8. U. S. DEA NUMBER _____ NPI NUMBER _____

AFFIDAVIT QUESTIONS

		YES	NO
1.	Have you ever been convicted of a felony?	☐	☐
2.	Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine?	☐	☐
3.	Have you ever been convicted of any violation of a state or federal law relating to controlled substances?	☐	☐
4.	Are any charges against you for violation of state or federal drug laws currently pending in any court?	☐	☐
5.	Have you ever been denied a state or federal controlled substances certificate or have had such a certificate revoked, restricted, conditioned or curtailed?	☐	☐
6.	Have you ever surrendered a state or federal controlled substance certificate for any reason?	☐	☐
7.	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?	☐	☐
8.	Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice?	☐	☐
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?	☐	☐
10.	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?	☐	☐
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 medicine with reasonable skill and safety to patients?	☐	☐
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?	☐	☐
13.	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?	☐	☐

		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?	☐	☐
15.	During any postgraduate training were you ever on probation, restrictions, suspension, revocation, modification, or otherwise acted against (explain "otherwise" actions)?	☐	☐
16.	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?	☐	☐
17.	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.	☐	☐
18.	Have you ever been denied medical malpractice liability insurance?	☐	☐
19.	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?	☐	☐
20.	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.

21. Have you ever applied for, or been denied a Mississippi medical license? _____

22. Have you ever served in the US Military? _____ Branch _____ Dates_____

23. Do you currently have an anticipated date to begin practice in Mississippi? _____ Date_____

I. RESIDENCY TRAINING PROGRAM

List name and address of residency program in which you will be training.

	Program Name	Institution	City, State, Zip
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

II. MEDICAL EDUCATION

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

	Date	Name	Address	City/State
1.	_____ to_____	_____	_____	_____
2.	_____ to_____	_____	_____	_____
3.	_____ to_____	_____	_____	_____

III. INTERNSHIP, RESIDENCY AND/OR FELLOWSHIP TRAINING

(Do not list practice experience)

List in chronological order all internship, residency, and/or fellowship training since graduation from medical school with dates and complete addresses of institutions. Specify training program, i.e., Family Practice, OB/GYN, etc.

	Date	Hospital/Institution	City/State	Training Program
1.	_____ to_____	_____	_____	_____
2.	_____ to_____	_____	_____	_____
3.	_____ to_____	_____	_____	_____
4.	_____ to_____	_____	_____	_____
5.	_____ to_____	_____	_____	_____

IV. ACTIVITIES FOLLOWING MEDICAL SCHOOL

List all activities in chronological order since completion of medical school giving dates, institutions/hospitals, and complete addresses. All activities following medical school must be accounted for. Use separate sheet if necessary.

	Date	Place	Address	City/State
1.	_____ to_____	_____	_____	_____
2.	_____ to_____	_____	_____	_____
3.	_____ to_____	_____	_____	_____
4.	_____ to_____	_____	_____	_____
5.	_____ to_____	_____	_____	_____

V. HOSPITAL PRIVILEGES

List all hospitals in chronological order where you have held staff privileges of any type. Post-graduate training sites should not be listed. Use a separate sheet if necessary.

	Date	Place	Address	City/State
1.	_____ to_____	_____	_____	_____
2.	_____ to_____	_____	_____	_____
3.	_____ to_____	_____	_____	_____
4.	_____ to_____	_____	_____	_____
5.	_____ to_____	_____	_____	_____

VI. STATE LICENSURE

List all states where you have been licensed to practice medicine or have applied for a license to practice medicine. 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
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

VII. LICENSING EXAMINATION

1. List date and score of licensing examination taken: (If dates and scores are unknown, indicate which examination was taken).

	Date	Score
USMLE		
Step I	_____	_____
Step II CK	_____	_____
Step II CS	_____	_____
Step III	_____	_____
National Board of Osteopathic Medical Examiners		
Part I	_____	_____
Part II CE	_____	_____
Part II PE	_____	_____
Part III	_____	_____
LMCC	_____	_____

If applicable, ECFMG #_____ Date Issued_____

AFFIDAVIT AND PERPETUAL RELEASE OF INFORMATION

I, _____, certify after being duly sworn, that all of the information supplied in the Mississippi State Board of Medical Licensure's restricted temporary license 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 release. I acknowledge that any false or untrue statement or representation made in the restricted temporary license application may result in the denial of initial licensure or 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 the restricted temporary license application and any information submitted with it or information collected by the Mississippi State Board of Medical Licensure in connection with the restricted temporary license 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 authorize each educational institution at which I have applied for any license, permit, certificate or registration; each person, firm, corporation, clinic, office, or institution by whom or with whom I have been employed in the practice of medicine; any hospital at which I have or have had membership; each insurance company with which I have obtained or made application for medical malpractice liability insurance; each physician or other health care practitioner with whom I have consulted or seen for diagnosis or treatment; and each professional organization or specialty board to which I have applied for membership, to disclose and release to the Mississippi State Board of Medical Licensure, 1867 Crane Ridge Drive, Suite 200-B, Jackson, MS 39216, any and all information and documentation concerning me which the Board deems material for consideration of my application. Further, I hereby consent to the disclosure and release of such information and documentation to the Mississippi State Board of Medical Licensure and waive any privilege or right of confidentiality which I would otherwise possess with respect thereto.

I further authorize any person, firm, corporation, clinic, office, institution, state or federal agency from whom the Mississippi State Board of Medical Licensure has requested information to rely on a copy of this release, the original now on file in the office of the Mississippi State Board of Medical Licensure at the above noted address.

I also agree to execute any other release or authorization, the execution of which may be required under federal or state law prior to release of any of the documents or information requested. Otherwise, this authorization shall constitute and operate as a perpetual authorization by me for all purposes set forth therein.

Date _____ _____
Applicant's Signature

County of _____

State of _____

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

_____
Notary Public

My Commission Expires:_____

(SEAL)

Attach a Passport-Type Photograph Taken Within 60 Days.

Informal Snapshots Will Not Be Accepted.

Complete and Submit to:
Mississippi State Board of Medical Licensure
1867 Crane Ridge Drive, Suite 200-B
Jackson, MS 39216

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
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WWW.MSBML.MS.GOV

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**

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)	☐ Yes ☐ 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)	☐ Yes ☐ No
Did instructors ever file any negative reports on this physician? (If yes, please explain)	☐ Yes ☐ No
Did physician take any type of leave of absence or break from his/her training? (If yes, please explain)	☐ Yes ☐ No

Signature of Program Director/Chairman			
Title		Signature Date	
Email address		Telephone No.	

INSTRUCTIONS TO INDIVIDUAL COMPLETING THIS FORM:

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FAX NOT ACCEPTABLE

APPENDIX C

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.	

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FAX NOT ACCEPTABLE

APPENDIX D

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 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 membership? (If yes, please explain)	☐ Yes ☐ No						
Signature of Certifying Official							
Title		Signature Date					
Email address		Telephone No.					

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FAX NOT ACCEPTABLE **APPENDIX E**

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:

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