

## Chapter 04 Temporary Licensure

### Short-Term Training for Out-of-State Physicians

- 400 The Board is aware that there are Mississippi physicians assisting out-of-state physicians in expanding professional knowledge and expertise by offering short-term training to the out-of-state physician. The Mississippi physician wishing to offer this training to the unlicensed out-of-state physician(s) must have their short-term training program approved by the Board.
- 401 The Mississippi physician must submit a detailed letter stating the purpose of the short-term training program, the objectives of the course, approximately how long the course will last, and any supporting documentation that would assist the Board in determining the approval status of the program.
- 402 An individual wishing to attend the Board approved short-term training is not required to obtain a permanent Mississippi medical license; however, the individual must submit the following to the Board:
1. A completed information form which has been supplied by the Board.
  2. A letter from the mentor of the Board approved training program stating that the applicant is going to be participating in the short-term training program and the duration.
  3. Verification of a current unrestricted permanent license from the state in which the individual is currently practicing.
  4. A permit fee in the amount of \$25.
- 403 The individual may not participate in the short-term training program until a valid training permit has been issued. The permit will be effective the date the individual is to begin the training and will become null and void the day the individual completes the training.
- 404 A short-term training permit is typically valid for two to three days; however, it can be issued up to fifteen (15) days. If during the duration of the training, it is determined that the physician may stay longer than fifteen (15) days, the temporary training permit may be renewed for an additional (15) days. Under no circumstances will the permit be renewed after thirty (30) days. An individual anticipating training for a period longer than thirty (30) days will be required to obtain a permanent Mississippi medical license.



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## Short-Term Training Permit

<b>Name:</b>		<b>Date of Birth:</b>
<b>Mailing Address:</b>		<b>Current Practice Location:</b>
<b>Mississippi Training Location:</b>		
<b>Telephone Number:</b>		<b>Email Address:</b>
<b>Current State of Licensure:</b>	<b>License Number:</b>	<b>Type of License:</b>
1. Have you ever been convicted of a felony?		<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been convicted of a crime or offense (felony or misdemeanor) related to the practice of medicine?		<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever been convicted of any violation of a state or federal law relating to controlled substances?		<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are any charges against you for violation of state or federal drug laws currently pending in any court?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever surrendered a state or federal controlled substance certificate for any reason?		<input type="checkbox"/> Yes <input type="checkbox"/> No
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?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
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?		<input type="checkbox"/> Yes <input type="checkbox"/> 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 medicine with reasonable skill and safety to patients?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No

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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Have you ever had a judgement rendered against you, or action settled relating to the performance of your professional service?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	Have you ever been denied medical malpractice liability insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19.	Have you ever been arrested, other than minor traffic citations?	<input type="checkbox"/> Yes <input type="checkbox"/> No

***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, \_\_\_\_\_, 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. 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.

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: \_\_\_\_\_

<b>OFFICE USE ONLY:</b>	<b>Permit Number:</b>	<b>Issue Date:</b>
	<b>Expiration Date:</b>	<b>Date Processed:</b>