MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

Cypress Ridge Building • 1867 Crane Ridge Drive, Suite 200-B • Jackson, MS 39216 (601) 987-3079

APPENDIX G

REQUEST FOR MEMBERSHIP VERIFICATION FROM THE AMERICAN PODIATRIC MEDICAL ASSOCIATION

TO APPLICANT:

Please complete the following information and submit to the American Podiatric Medical Association, ATTN: Membership Services Dept., 9312 Old Georgetown Road, Bethesda, Maryland, 20814, along with a check or money order in the amount of \$15.00.

Full Name of DPM		
Professional Mailing Address		
Place of Birth	Date of Birth	
Podiatric School of Graduation		
TO AMERICAN PODIATRIC ME	EDICAL ASSOCIATION:	
from you. Enclosed is a \$15.0 Please accept this as my reques	Medical License, I must have a Membership Verification 00 check or money order to cover the processing fee. st to send a Membership Verification to the Mississippi ure, 1867 Crane Ridge Drive, Suite 200-B, Jackson,	
Physician Signature	Date	

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. Please do not send this application back to the applicant as the Board will not consider this certification unless it is received directly from the institution. Board policy requires original documents, please do not fax.

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APPENDIX H

REQUEST FOR RESIDENCY TRAINING VERIFICATION FROM THE AMERICAN PODIATRIC MEDICAL ASSOCIATION

TO APPLICANT:

Please complete the following information and submit to the American Podiatric Medical Association, ATTN: Council on Podiatric Medical Education (CPME), 9312 Old Georgetown Road, Bethesda, Maryland, 20814, along with a check or money order in the amount of \$15.00.

Full Name of DPM	
Professional Mailing Address	
-	
Place of Birth	Date of Birth
Name of Residency Program	
Dates of Residency Program	
TO AMERICAN PODIATRIC ME	DICAL ASSOCIATION:
Verification from you. Enclose processing fee. Please accept	i Medical License, I must have a Residency Training ed is a \$15.00 check or money order to cover the t this as my request to send a Residency Training State Board of Medical Licensure, 1867 Crane Ridge lississippi 39216.
Physician Signature	Date

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. Please do not send this application back to the applicant as the Board will not consider this certification unless it is received directly from the institution. Board policy requires original documents, please do not fax.