Prior to the issuance of, or reinstatement of a license, any physician, osteopathic physician, or podiatrist who has not actively practiced for a three (3) year period shall be required to participate in a Board approved physician assessment program and/or clinical skills assessment program to assure post-licensure competency.

A physician shall be deemed to have not "actively" practiced medicine if during said three (3) year period the physician has not treated any patients for remuneration, other than friends and family.

This section excludes those physicians, osteopathic physicians, or podiatrists who perform charity work or work in research.

Any physician, osteopath or podiatrist not practicing in Mississippi who allows his license to lapse by failing to renew the license may be reinstated by the board on satisfactory explanation for the failure to renew, by completion of a reinstatement form and upon payment of the arrearages for the previous five (5) years plus the current year and shall be assessed a fine of Twenty-five Dollars ($25.00) per year plus an additional fine of Five Dollars ($5.00) for each month that the license remains delinquent.

(A) **General Information Questions 1-9.** Application questions must be completed by the applicant. Please either type or print this page.

(B)**Affidavit Questions 1-20.** Affidavit questions must be completed by the applicant. A detailed explanation for any affirmative answer must be attached.

(C) **Section I.** Applicant must account for all time and activities since initial issuance of MS medical license. The intentional failure to disclose any time period shall constitute falsification which is grounds for denial of the application.

(D) **Section II.** Applicant must list all hospitals where privileges have been held, other than training hospitals, since issuance of initial MS license.

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

(F) **Section IV.** Applicant shall read carefully the oath of the truthfulness of information supplied in this application and the releases which give consent to release information to and from the Board. Applicant shall execute the application and have notarized.

(G) **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.

Duplicate as many copies of each appendix as you need.

(H) **Appendix A.** Verification of all licenses held must be primary source verified directly to MSBML, including 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.

(I) **Appendix B.** Applicant must provide verification from primary source for all time since initial issuance of MS medical license. 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.

(J) **Appendix C.** 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.

(K) **Request Pertaining to Military Records Form.** If applicant has served in any branch of the military since initial issuance of MS medical license, applicant must go to http://www.archives.gov/veterans/military-service-records/ to request DD Form 214 or equivalent to be sent to this

office. If applicant is currently enlisted, a letter from current station will be acceptable.

(L) **Application Fees.** Applicant must submit check or money order made payable to the MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE in the amount of $250.00. This $250.00 is a non-refundable filing fee, but will be applied to the total reinstatement fee once application has been completed.

(M) If your MS license has been expired 5 years or more, you will be required to appear at the office of the Board for a personal interview, take the jurisprudence examination and submit for a criminal background check (fingerprinting) which will be submitted to the Federal Bureau of Investigations (FBI).

NO FOREIGN CHECKS OR MONEY ORDERS WILL BE ACCEPTED.

NOTE* INFORMATION PERTAINING TO APPLICATION AND REINSTATEMENT OF MEDICAL LICENSE IS GIVEN TO THE <u>APPLICANT ONLY</u>. 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 MAILED OUT WEEKLY.

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 letters of recommendation, 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.

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

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JACKSON, MISSISSIPPI 39216
(601) 987-3079

APPLICATION FOR REINSTATEMENT OF LICENSE

GENERAL INFORMATION

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

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

3. PLACE OF BIRTH _____ (CITY AND STATE OR COUNTRY) DATE OF BIRTH _____ (MO/DA/YR)

4. SOCIAL SECURITY NUMBER _____ GENDER _____

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

6. E-MAIL ADDRESS _____

7. U. S. DEA NUMBER _____ NPI NUMBER _____

8. MISSISSIPPI LICENSE NUMBER _____ ISSUE DATE _____ EXPIRATION DATE _____

9. MILITARY SERVICE - BRANCH _____ DATES _____

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?	☐	☐
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?	☐	☐

		YES	NO
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.

I. ACTIVITIES FOLLOWING ISSUANCE OF MS MEDICAL LICENSE

List all activities in chronological order since issuance of your Mississippi medical license giving dates, institutions/hospitals, and **complete** addresses. **All** activities following initial issuance of Mississippi medical license must be accounted for. Use separate sheet if necessary.

	DATE	PLACE	ADDRESS	CITY/STATE
1.	_____ to _____	_____	_____	_____
2.	_____ to _____	_____	_____	_____
3.	_____ to _____	_____	_____	_____
4.	_____ to _____	_____	_____	_____
5.	_____ to _____	_____	_____	_____

II. HOSPITAL PRIVILEGES

List all hospitals in chronological order where you have held staff privileges of any type since the issuance of your Mississippi medical license. 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 _____	_____	_____	_____

III. 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
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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.

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: _____

PHOTOGRAPH

(wallet-size, passport-type)

TAKEN WITHIN

SIXTY (60) DAYS

must be attached here with

tape. Do not paste.

COMPUTER GENERATED OR

INFORMAL SNAPSHOTS

WILL NOT BE ACCEPTED

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FAX NOT ACCEPTABLE **APPENDIX A**

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.

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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:

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FAX NOT ACCEPTABLE

APPENDIX C

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.					

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.