Reset Form

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

ANNUAL RENEWAL OF RADIOLOGIST ASSISTANT LICENSE

JULY 1, 2017 THROUGH JUNE 30, 2018

PERSONAL INFORMATION

NAME (LAST, FIRST M.):

LICENSE NUMBER:

E-MAIL ADDRESS:

HOME PHONE: ( ) –

PRIMARY PRACTICE

STREET ADDRESS:

ENTER A PHYSICAL ADDRESS.
PO BOXES ARE NOT ACCEPTABLE.

CITY: STATE: ZIP: –

OFFICE PHONE: ( ) –

COUNTRY:

OFFICE FAX: ( ) –

MAILING ADDRESS

STREET ADDRESS OR PO BOX:

COUNTRY:

CITY: STATE: ZIP: –

SECONDARY PRACTICE

STREET ADDRESS:

ENTER A PHYSICAL ADDRESS.
PO BOXES ARE NOT ACCEPTABLE.

CITY: STATE: ZIP: –

COUNTRY:

AFFIDAVIT QUESTIONS

1. FROM JULY 1, 2015, TO THE PRESENT, HAVE YOU BEEN THE SUBJECT OF ANY DISCIPLINARY ACTION OR INVESTIGATION BY ANY US OR FOREIGN LICENSING AUTHORITY, HOSPITAL, INSTITUTION, SOCIETY, OR OTHER GOVERNMENTAL AGENCY?

☐ **YES** ☐ **NO**

IF ANSWER IS YES, PLEASE PROVIDE A DETAILED EXPLANATION BELOW:

2. FROM JULY 1, 2015, TO THE PRESENT, HAVE YOU ENTERED A PLEA BARGAIN OR HAVE YOU BEEN ARRESTED, CHARGED, INDICTED, OR CONVICTED FOR VIOLATING ANY LAW, INCLUDING DUI (DO NOT REPORT MINOR TRAFFIC VIOLATIONS)?

☐ **YES** ☐ **NO**

IF YES, EXPLAIN BELOW AND ATTACH COPY OF CONVICTION ORDER, PLEA BARGAIN OR CERTIFIED COPY OF COURT ABSTRACT TO THIS FORM.

3. FROM JULY 1, 2015, TO THE PRESENT, HAVE YOU RECEIVED TREATMENT FOR PSYCHIATRIC, ADDICTION OR SUBSTANCE USE RELATED ISSUES NOT KNOWN TO THE MPHP? (IF YOU ARE AN ANONYMOUS PARTICIPANT IN THE MISSISSIPPI PROFESSIONALS HEALTH PROGRAM AND ARE IN COMPLIANCE WITH YOUR CONTRACT, YOU MAY ANSWER "NO" TO THIS QUESTION).

☐ **YES** ☐ **NO**

IF ANSWER IS YES, PLEASE PROVIDE A DETAILED EXPLANATION BELOW:

4. DURING THE PERIOD JULY 1, 2016 - JUNE 30, 2017, HAVE YOU ACQUIRED ANY OF YOUR 24 HOURS OF RADIOLOGICAL RELATED CONTINUING EDUCATION? (24 HOURS ARE REQUIRED BY JUNE 30, 2018.)

☐ **YES** ☐ **NO**

IF ANSWER IS YES, PLEASE PROVIDE A DETAILED EXPLANATION BELOW:

5. DO YOU HAVE A SUPERVISING PHYSICIAN?

☐ **YES** ☐ **NO**

IF YES, A SUPERVISING PHYSICIAN INFORMATION FORM MUST BE SUBMITTED FOR ALL SUPERVISING PHYSICIANS WHETHER PRIMARY OR SECONDARY. SEE FOLLOWING FORM.

6. HAS YOUR PROTOCOL CHANGED IN ANY WAY (I.E. DUTIES ADDED, DUTIES SUBTRACTED, SUPERVISION, ETC.)? IF YES, SUBMIT A SIGNED COPY OF UPDATED PROTOCOL FOR APPROVAL.

☐ **YES** ☐ **NO**

7. IF PRACTICE IS NOT IN MISSISSIPPI, WHY ARE YOU NOT PRACTICING MEDICINE IN THE STATE OF MISSISSIPPI?

- ○ RETIRED. YEAR OF RETIREMENT: _____
- ○ WORK IN ANOTHER FIELD
- ○ ACTIVE IN ANOTHER STATE
- ○ HOMEMAKER
- ○ IN PROFESSIONAL TRAINING
- ○ OTHER REASON: _____

Type of Employment

Choose from list of codes:

If "Other", please specify.

Setting of Employment

Choose from list of codes:

If "Other", please specify.

Codes

Type of Employment

Self Employment
10 Solo practice
11 Partnership or group owned practice
12 Locum tenens

Nongovernmental Employee of
13 Individual practitioner
14 Partnership or group of practitioners
15 Group health plan
16 Other nongovernmental employer (Specify)_____

Governmental Employee
17 Local government (other than county or state)
18 County government
19 State government
20 Federal government (USPHS and civilians other than VA)
21 Federal government (Armed forces personnel only)
22 Federal government (VA)

Other Forms of Employment
23 Unpaid voluntary worker
24 Other (Specify)_____

Setting of Employment

Nonfederal Health Facility
50 Hospital (other than mental)
51 Mental hospital
52 Nursing home
53 Clinic, free standing
54 Group health plan facility
55 Practitioner's office
56 Hospital and office

Federal Health Facility
57 Health facility on military installation
58 VA
59 Public health, Indian health, and civilian other than VA

School
60 School of medicine or dentistry
61 School of nursing
62 University or college other than medical, dental, or nursing
63 School or treatment center for the handicapped or disabled
64 Residency training program
65 Other schools (specify)_____

Miscellaneous Places
66 Patients' homes
67 Medical research institution or establishment
68 Professional or allied health association
69 Administrative or regulatory health agency
70 Manufacturing or industrial establishment
71 Retail, wholesale, or other business establishment

Other Settings of Employment
72 Other (Specify)_____

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
Instructions for Completing Application for Renewal
July 1, 2017, through June 30, 2018

AFFIDAVIT

I acknowledge that all information contained in this renewal application has been either directly submitted by me or caused to be submitted by me. I acknowledge that all information submitted is true and correct to the best of my knowledge. Any information erroneously submitted either directly by me or submitted by my direction is my responsibility. I understand that investigations and disciplinary action may result from the knowing or willful failure of me to submit information, either directly or indirectly, to the Board or from the submission of incorrect information to the Board.

Signature **Date**

RENEWAL FEES

The 2017-2018 annual renewal fee is $150.00. (If received by the Board before July 1, 2017). After June 30, 2017, each renewal shall include $25.00 additional fine plus $5.00 for each month thereafter that the license renewal remains delinquent.

All incomplete applications will be returned and processing will be delayed. A $10.00 fee will be assessed each time a renewal application is returned due to incompleteness.

A $50.00 fee will be charged for all returned checks.

In order to maintain a current radiologist assistant license, this application must be completed, signed and returned along with renewal fee to:

Mississippi State Board of Medical Licensure
Radiologist Assistant Renewals
1867 Crane Ridge Drive, Suite 200-B
Jackson, MS 39216

(601) 987-3079

SUPERVISING PHYSICIAN INFORMATION FORM

LICENSE NUMBER:

FIRST NAME:

MIDDLE NAME:

LAST NAME:

SUFFIX:

STREET ADDRESS:

CITY: STATE: ZIP: –

COUNTRY:

☐ PRIMARY
☐ SECONDARY

PHYSICIAN FOR RADIOLOGIST ASSISTANT?