



MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

ANNUAL RENEWAL OF RADIOLOGIST ASSISTANT LICENSE

JULY 1, 2018 THROUGH JUNE 30, 2019



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, 2016, 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, 2016, 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, 2016, 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, 2017 - JUNE 30, 2018, 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	SETTING OF EMPLOYMENT
<p>SELF EMPLOYMENT 10 SOLO PRACTICE 11 PARTNERSHIP OR GROUP OWNED PRACTICE 12 LOCUM TENENS</p> <p>NONGOVERNMENTAL EMPLOYEE OF 13 INDIVIDUAL PRACTITIONER 14 PARTNERSHIP OR GROUP OF PRACTITIONERS 15 GROUP HEALTH PLAN 16 OTHER NONGOVERNMENTAL EMPLOYER (SPECIFY) _____</p> <p>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)</p> <p>OTHER FORMS OF EMPLOYMENT 23 UNPAID VOLUNTARY WORKER 24 OTHER (SPECIFY) _____</p>	<p>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</p> <p>FEDERAL HEALTH FACILITY 57 HEALTH FACILITY ON MILITARY INSTALLATION 58 VA 59 PUBLIC HEALTH, INDIAN HEALTH, AND CIVILIAN OTHER THAN VA</p> <p>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) _____</p> <p>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</p> <p>OTHER SETTINGS OF EMPLOYMENT 72 OTHER (SPECIFY) _____</p>

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
Instructions for Completing Application for Renewal
July 1, 2018, through June 30, 2019

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 2018-2019 annual renewal fee is \$150.00. (If received by the Board before July 1, 2018). After June 30, 2018, 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 PHYSICIAN FOR RADIOLOGIST ASSISTANT?
 SECONDARY