

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
Cypress Ridge Building • 1867 Crane Ridge Drive, Suite 200-B • Jackson, MS 39216
(601) 987-3079

APPENDIX D

VERIFICATION OF LICENSURE

PLEASE COMPLETE TOP PORTION AND FORWARD ONE TO EACH STATE IN WHICH YOU HOLD OR HAVE HELD A LICENSE TO PRACTICE AS A PHYSICIAN ASSISTANT. Extra copies may be made if needed. This form is considered part of your application. Therefore, your file will not be reviewed if you are or have been licensed in another state and this form is missing.

NOTE: Some State Boards require a fee, paid in advance, for providing clearance information.

THIS FORM WILL NOT BE ACCEPTED IF RETURNED BY THE APPLICANT.

REQUEST FOR CLEARANCE FROM OTHER STATE BOARDS

I was granted license, certification or registration # _____ on _____ by the State of _____.

The Mississippi State Board of Medical Licensure requests that I submit evidence that my license in the State of _____ is in good standing.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Mississippi State Board of Medical Licensure, 1867 Crane Ridge Drive, Suite 200-B, Jackson, Mississippi, 39216. Your early attention to this request will be appreciated.

Signature

Print or type name

EXECUTIVE OFFICER OF STATE BOARD:

Please complete and return this form to the Mississippi State Board of Medical Licensure, 1867 Crane Ridge Drive, Suite 200-B, Jackson, Mississippi, 39216.

State of _____ Name of Licensee _____
License # _____ Date Issued _____ Is License Current? _____ If yes, expiration date _____ Has applicant's license ever been suspended, revoked or had restriction imposed? _____ If so, please attach supporting documents. Is applicant currently under investigation for any reason? _____ If so, for what reason? _____

Other derogatory information _____

Signed _____

(Board Seal)

Title _____

Date _____