Mississippi State Department of Health

Verification of Credential in Another State

To be Completed by Applicant (Please print or type)

Social Security Number: ________-_______-________

Name: ____

Credentialing Authority: ____________________ Number: ________________________ Date Issued: ____________________

State, Territory, or Country

____
Applicant Signature

To be Completed by the Credentialing Board

Name: ____

Type of Credential: ____

Number: ____

Date Issued: ____

Expiration Date: ____

Issued by:

State Exam: ____

Reciprocity with: ____

Credential: ____

Has credential ever been disciplined? ❑ No ❑ Yes (If yes, please attach findings and disposition.)

Remarks: ____

____

____

Board must return to:

Mississippi State Department of Health
Bureau of Professional Licensure
MSDHProfLicensure@msdh.ms.gov

____
Authorized Signature

This document must show Seal of credentialing agency.

Seal