MISSISSIPPI STATE DEPARTMENT OF HEALTH

TELEMEDICINE RENEWAL APPLICATION
COMPLETE ALL INFORMATION BELOW

1. Provider/Organization Name: _____

2. Owner's Name: _____
   (Last) *(First)* *(Middle/Maiden)*

3. Provider/Organization Address: _____
   (Street)

   _____
   (City) *(State)* *(Zip Code)* *(County)*

4. Owner's E-mail Address: _____

5. Telephone Number: (_____) _____

6. Name(s) of individual(s) practicing telemedicine, profession practiced, and license number (*you may provide a typed list with the requested information in lieu of completing this section).*

   _____

   _____

   _____

   _____

   _____

7. Attach a copy of your Mississippi Secretary of State certificate of registration.

8. Attach proof of your business' liability insurance.

I, the undersigned, do solemnly swear or affirm that I am the above applicant and all statements contained therein or accompanying this application are true to the best of my knowledge and belief. I have also read and understand the Minimum Standards of Operation Relative to the Practice of Telemedicine and affirm that all conditions for registration have been met and will be maintained.

_____ _____

Signature of Applicant **Date**

Complete this form, enclose a $50.00 money order, a copy of the Mississippi Secretary of State's office registration certificate, and a copy of your proof of liability insurance. Mail all items to Mississippi State Department of Health, Professional Licensure – Telemedicine, P. O. Box 1700, Jackson, MS 39215-1700.