

**FORM 1R
REINSTATEMENT**

MISSISSIPPI DEPARTMENT OF EDUCATION

Office of Educator Licensure
P. O. Box 771
Jackson, MS 39205-0771
TELEPHONE (601) 359-3483

OFFICE USE ONLY

Application Complete
//_/

APPLICATION FOR REINSTATEMENT OF AN EDUCATOR'S LICENSE

(PRINT OR TYPE ALL INFORMATION)

PART A - GENERAL INFORMATION

NAME: _____ SOCIAL SECURITY NUMBER: _____
Last First Middle

DATE OF BIRTH: ____/____/____
Mo. Day Yr.

STATE ANY OTHER NAMES
OR ALIASES YOU HAVE
BEEN KNOWN BY: _____

LEGAL MAILING ADDRESS: _____
Box or Street
City State Zip Code

TELEPHONE (____) _____ - _____
Work
TELEPHONE (____) _____ - _____
Home

LICENSURE: Teacher _____ Endorsement (s) _____ License No: _____
Administrator _____ License No: _____

DATE ISSUED: ____/____/____
Mo. Day Yr.
DATE ISSUED: ____/____/____
Mo. Day Yr.

Are you represented by an attorney in this matter? YES NO If yes, state name, address and telephone number below:

Attorney Name Address City State Zip Code Telephone

PART B - GENERAL QUESTIONS

Other than the actions associated with the revocation/surrender/suspension/denial of your license,

1. Have you ever been convicted of a crime (felony or misdemeanor) in any state or country? YES NO
2. Are there any pending criminal charges against you? YES NO
3. Have you been found guilty of professional misconduct, unprofessional conduct, incompetence, or negligence in any state or country other than Mississippi? YES NO
4. Has any licensing authority suspended, revoked or restricted your license or imposed any other disciplinary action? YES NO
5. Have you ever had charges brought against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state other than Mississippi or any other country other than the United States? YES NO
6. Have you ever been requested to appear before or submit an explanation to any licensing authority in regard to any charges or complaints? YES NO
7. Have you ever been denied a license or the opportunity to take an examination for licensure by any licensing authority? YES NO
8. Has any school restricted or terminated your professional training or employment or have you voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures? YES NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PROVIDE A FULL EXPLANATION ON A SEPARATE SHEET OF PAPER FOR EACH ITEM. YOU MUST INCLUDE ANY OFFICIAL VERIFYING DOCUMENTATION FOR EACH ITEM.

9. Have you ever received counseling or treatment connected with the revocation/surrender/suspension/denial of your license? YES NO
If yes, (1) attach a statement from the treating practitioner/facility regarding your current diagnosis and prognosis, including your ability to resume the practice as an educator and (2) present an original, executed release to each practitioner or facility where you have had treatment to have treatment records submitted directly to the Office of Educator Licensure. Treatment records must include the Intake, Admission Diagnosis, Plan of Treatment, Discharge Summary, Discharge Diagnosis and Recommendations. A release form has been enclosed for your convenience.

10. List the following requested information for each counseling or treatment received which is related to the reason for the revocation/surrender/suspension/denial of your license.

FROM MONTH-YEAR	TO MONTH-YEAR	TYPE OF TREATMENT	PLACE & ADDRESS OF TREATMENT

11. Was your license suspended, revoked, denied or surrendered for drug-related offenses? YES NO

If yes, (1) You should be evaluated for chemical dependency and chemical abuse by an health-care professional with expertise in chemical dependency/chemical abuse; (2) If you are diagnosed with a chemical dependency or chemical abuse, you should follow the treatment plan determined by your treatment program and submit with this application documentation from your counselor or contact person with the treatment management team that you have followed your treatment program; (3) You should remain in a treatment and after-care program for the period recommended by your counselor and submit with this application a letter of final assessment .

PART C - CONTINUING EDUCATION

1. List any continuing education credits you earned since the revocation/surrender/suspension/denial of your license. Submit proof for each item listed. If additional space is required, attach a separate list.

COURSE/SEMINAR ATTENDED	DATE(S) OF ATTENDANCE	CREDIT HOURS

2. List other methods, if any, that you have used to maintain/improve your knowledge and skill in the practice of your profession since the date of revocation/surrender/suspension/denial of your license. If additional space is required, attach a separate list.

3. Explain how the educational preparation (listed in items 1 & 2 above) is relevant to the specific conduct that resulted in the loss of your license.

PART D - COMMUNITY SERVICE

List any community or public service related activities you have been involved in since the date of the revocation/surrender/suspension/denial of your license. Submit documentation for each activity listed. If additional space is required, attach a separate sheet.

TYPE OF ACTIVITY	NAME OF ORGANIZATION	DATE(S)	NUMBER OF HOURS

PART E - LICENSURE STATUS

1. Are you licensed or have you ever held an educator's license in any other state or country? YES NO

If yes, list each jurisdiction. A Verification of Licensure in Another Jurisdiction (Form 3R) must be submitted for each license (including all inactive licenses) listed.

State or Country	Profession	Date License Issued	Any Limitations on License	If License is not Current, Explain Below or on Separate Sheet

2. Have you ever held or do you currently hold a Mississippi license in another profession? YES NO

If yes, complete section below.

Profession	License Number	Date of Licensure	Current Status

PART F - EMPLOYMENT HISTORY

List all employment chronologically since graduation from college to the present. Explain periods of unemployment. If additional space is required, attach a separate sheet. Begin with date of graduation from college and end with the present date.

FROM Month – Year	TO Month – Year	REASON FOR EMPLOYMENT TERMINATION / RESIGNATION	Employers
			Employer: Address: Position held: Telephone (____) ____ - ____ Duties:
			Employer: Address: Position held: Telephone (____) ____ - ____ Duties:
			Employer: Address: Position held: Telephone (____) ____ - ____ Duties:
			Employer: Address: Position held: Telephone (____) ____ - ____ Duties:
			Employer: Address: Position held: Telephone (____) ____ - ____ Duties:

PART G - PROFESSIONAL REHABILITATION ACTIVITIES

List any professional practice-related rehabilitation activities which you have undertaken to address the action(s) which resulted in the loss or denial of your license. Submit documentation for each activity listed. If additional space is required, attach a separate sheet.

PART H - SUBMISSION OF AFFIDAVITS

An application for reinstatement will not be considered complete without at least 5 notarized supporting affidavits (Form 4R) attached. Three of the required five affidavits must be from individuals licensed and in good standing in your profession. List the names and telephone numbers of the individuals for which you have attached affidavits. If additional space is required, attach a separate sheet. Include the required affidavits along with this application for reinstatement form and return to the address shown on page 5.

Name _____	Telephone Number _____
Name _____	Telephone Number _____
Name _____	Telephone Number _____
Name _____	Telephone Number _____
Name _____	Telephone Number _____
Name _____	Telephone Number _____

PART I - CERTIFICATION

Under penalties of perjury, I declare and affirm that the statements made in this application, including accompanying documents are true, complete, and correct. I understand that any false or misleading information in, or in connection with my application may be cause for denial of licensure.

Signature of Petitioner

Date

Sworn to before me this ____ day of _____, _____,

Signature of Notary

My Commission Expires: _____

(Notary Seal)

RETURN TO: Mississippi Department of Education, Office of Educator Licensure, P. O. Box 771, Jackson, MS 39205-0771.

FORM 2R
REINSTATEMENT

MISSISSIPPI DEPARTMENT OF EDUCATION

Office of Educator Licensure
P. O. Box 771
JACKSON, MS 39205-0771
TELEPHONE (601) 359-3483

This form is to be completed ONLY by applicants who answered "YES" to question # 9 in Part B of Form 1R.

AUTHORIZATION TO RELEASE TREATMENT RECORDS

INSTRUCTIONS: If you answered "Yes" to question # 9 in Part B of the Application Form 1R, you must complete a separate authorization form for each professional practitioner and/or hospital/facility where you have been treated. If additional forms are needed, this form may be photocopied. DO NOT MAIL THIS AUTHORIZATION SEPARATELY. Copies of the completed authorizations must be attached to your application for reinstatement. You must submit the original authorization(s) directly to the treatment facility/facilities.

I, (print your name here) _____, request and authorize the **below-named** licensed professional or practitioner or the **below-named** hospital or facility, to disclose fully to the Mississippi Department of Education, Office of Educator Licensure and its authorized representatives all information and records relating to the diagnosis, treatment, prognosis made for and/or on my behalf, or service rendered for and/or on my behalf, by the said licensed professional, practitioner, hospital, or facility. I understand that this consent may be withdrawn by me at any time except to the extent that the action has been taken in reliance upon it. In any event, this consent shall expire when the Mississippi Department of Education and/or the Commission on Teacher and Administrator Education, Certification and Licensure and Development and/or the Mississippi Board of Education has/have taken final action on my petition for reinstatement of my educator license. I also understand that my disclosure is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records. In accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by law.

Name of practitioner _____ License No. _____

or

Name of hospital or other facility _____

Signature of petitioner _____ Date _____

**FORM 3R
REINSTATEMENT**

MISSISSIPPI DEPARTMENT OF EDUCATION

Office of Educator Licensure
P. O. Box 771
JACKSON, MS 39205-0771
TELEPHONE (601) 359-3483

This form is to be completed ONLY by applicants who are or have been licensed in another jurisdiction.

VERIFICATION OF LICENSURE IN ANOTHER JURISDICTION

APPLICANT INSTRUCTIONS

1. Complete Sections I and II. Enter your name as it appears on your Application Form 1R.
2. DO NOT RETURN THIS FORM WITH YOUR APPLICATION. Send this form to each state or country where you are or have ever been licensed and request that they complete Section III on back. Be sure to include any fee(s) required. If additional forms are needed, this form may be photocopied. You must provide Verification of Licensure and the status of your license from ALL jurisdictions where you are or have ever been licensed. Verifications must be in English or otherwise submitted with an official translation.

SECTION I: APPLICANT INFORMATION

1. SOCIAL SECURITY NUMBER ____ - ____ - ____ 2. BIRTH DATE ____ - ____ - ____
MO. DAY YR.
3. FULL NAME LAST _____
 FIRST _____
 MIDDLE _____
4. ADDRESS STREET _____
 CITY _____
 STATE _____ ZIP CODE _____
5. NAME OF JURISDICTION _____ DATE OF LICENSURE ____ - ____ - ____
MO. DAY YR.
- NAME UNDER WHICH YOU ARE OR WERE LICENSED IN THAT JURISDICTION _____
- LICENSE NUMBER _____ PROFESSION _____

SECTION II: APPLICANT RELEASE

I request and authorize the above named jurisdiction to release any and all information pertaining to my license, including but not limited to, disciplinary actions and pending charges.

SIGNATURE OF APPLICANT _____ DATE _____

JURISDICTION'S CERTIFICATION IS TO BE COMPLETED ON THE REVERSE SIDE

SECTION III: OTHER JURISDICTION'S CERTIFICATION. To be completed by the licensing authority. Do not return to applicant. Return completed form directly to: Mississippi Department of Education, Office of Educator Licensure, P. O. Box 771, Jackson, MS 39205-0771.

1. a. Has the applicant named in Section I been subject to any disciplinary action? YES NO
- b. Are any charges pending against this individual? YES NO

If the answer to either of these questions is "yes", please attach certified copies all relevant information.

2. LICENSE NUMBER _____ DATE ISSUED ___ / ___ / _____
MO. DAY YR.

Expiration of most recent registration ___ / ___ / _____ Is the license current? YES NO
MO. DAY YR.

I certify that the information shown above is true and correct, according to the records of this office.

Name of Jurisdiction: _____

Name: _____

Title: _____

(BOARD SEAL)

Signature: _____

Date: _____

Telephone Number: (____) ____ - _____

FAX Number: (____) ____ - _____

SECTION IV: OPTIONAL COMMENTS. To be completed by the licensing authority.

Comments _____

Return completed form directly to:

Mississippi Department of Education, Office of Educator Licensure, P. O. Box 771, Jackson, MS 39205-0771.
Telephone: (601) 359-3483.

FORM 4R
REINSTATEMENT

MISSISSIPPI DEPARTMENT OF EDUCATION

Office of Educator Licensure
P. O. Box 771
JACKSON, MS 39205-0771
TELEPHONE (601) 359-3483

SUPPORTING AFFIDAVIT

INSTRUCTIONS

APPLICANT: Complete items A and B and provide a copy to each of your affiants/references. Attach completed original of each affidavit to your reinstatement application.

AFFIANT/REFERENCE: Complete items 1 - 5, sign the affidavit in the presence of a notary public, and return the form to the applicant.

In the Matter of the Application of

A. _____
(Applicant's Name)

for the reinstatement of (his/her) license to practice as a

B. _____
(Type of License)

in the State of Mississippi.

This affidavit
is in support of an
application for
reinstatement of an
educator license.

State of _____)

)

County of _____)

_____, being duly sworn deposes and says:

1. My name is _____
(affiant/reference name)

I reside at _____
(affiant/reference address)

My daytime telephone number (include area code) is _____

My occupation is _____

I am a licensed professional YES NO

If yes, Profession: _____ State: _____

License Number: _____ Is the license current? YES NO

Date License Issued: ____/____/____ Expiration Date of Last Registration: ____/____/____

I am of sound mind, capable of making this affidavit and personally acquainted with the facts stated herein.

I make this affidavit in support of _____ application for reinstatement
of (his/her) license to practice as a _____ in the State of Mississippi.

2. I have known the applicant for _____ years and _____ months through the following contacts:

3. It is my understanding that the applicant's license was revoked, surrendered, suspended or denied because (provide a detailed statement of circumstances which led to revocation/surrender/suspension/denial of license):

4. It is my understanding that the applicant has undertaken the following activities to rehabilitate (himself/herself) (provide a detailed statement of activities):

5. I recommend that the applicant's license be reinstated because:

(Signature of Affiant/Reference)

Sworn to before me this _____ day of _____, _____.

Notary Public _____

My Commission Expires: _____

(NOTARY SEAL)

Licensure Application

(Must be LEGIBLY completed and submitted with all licensure requests.)

Applicant Information

Social Security Number: _____		Email Address _____	
Name _____		_____	
<i>Last</i>	<i>First</i>	<i>Middle/Maiden</i>	
Address: _____		_____	
<i>Street/P.O. Box</i>		<i>Apt.#</i>	
_____		<i>City</i>	<i>State</i>
		<i>Zip</i>	
Phone Number _____	Birthdate _____	Gender _____	
Ethnicity: (Ethnicity information is used for statistical purposes and to provide information required by the U.S. Department of Education in accordance with applicable federal regulations. Your cooperation in providing this information is appreciated.)			
<input type="checkbox"/> American Indian	<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black—non-Hispanic
<input type="checkbox"/> White—non-Hispanic	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Other

Licensure Request

Class of license for which you are applying: ___ A (Bachelor) ___ AA (Master) ___ AAA (Specialist) ___ AAAA (Doctorate)	Military Experience (Check, if applicable)
Type of License (See <i>Licensure Checklist</i> for descriptive information.) ___ Approved Program/Teacher Education Route ___ Subject Area (s): _____ ___ Alternate Route ___ Subject Area (s): _____ ___ Supplemental Endorsement Subject Area(s) _____ ___ Administrator License (Check level of license) ___ Non-practicing ___ Entry ___ Career ___ School Business Administrator ___ Three Year ___ Five Year ___ JROTC	
___ Duplicate ___ Reciprocity ___ Renewal/Reinstatement	
___ Reserve ___ MSNG ___ Coast Guard	

Character Determination

Check "yes" or "no" to the left of each question.

___ yes ___ no Are you currently addicted or currently dependent on alcohol?

___ yes ___ no Are you currently addicted or currently dependent on other habit-forming drugs?

___ yes ___ no Are you a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs having similar effects?

___ yes ___ no Have you been convicted or pled guilty to a felony as defined by federal or state law?***
 (For the purpose of this question, a "guilty plea" includes a plea of guilty, entry of a plea of *nolo contendere*, or entry of an order granting pretrial or judicial diversion.)

___ yes ___ no Have you been convicted or pled guilty to a sex offense as defined by federal or state law?*** (For the purpose of this question, a "guilty plea" includes a plea of guilty, entry of a plea of *nolo contendere*, or entry of an order granting pretrial or judicial diversion.)

___ yes ___ no Are you currently on probation or post-release supervision for a felony or sex offense conviction as defined by federal or state law?***

___ yes ___ no Have you had a certificate/license denied, suspended, and/or revoked by MS or another state? Have you voluntarily surrendered a certificate/license?

If you answered "yes" to any of the above provide on a separate sheet of paper the specifics or an explanation for the response. If you elect not to provide specifics or if such an explanation is insufficient, a confidential investigation will be initiated.

**If you answered "yes" submit official copies of court record including disposition of case.*

I acknowledge that securing or attempting to secure a license by fraud or deceit will result in denial of this application or suspension of the license.

Signature: _____ **Date:** _____

Mail application to: MS Dept. of Education • Office of Educator Licensure • P.O. Box 771 • Jackson, MS 39205-0771