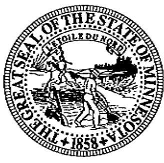


MINNESOTA BOARD OF MEDICAL PRACTICE

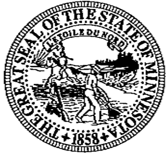
University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

2010

BOARD MEETING SCHEDULE
AND DEADLINE DATES

BOARD MEETING DATE	DEADLINE DATE
January 9, 2010	November 1, 2009
March 13, 2010	January 1, 2010
May 8, 2010	March 1, 2010
July 10, 2010	April 1, 2010
September 11, 2010	June 1, 2010
November 13, 2010	September 1, 2010
January 8, 2011	November 1, 2010

The completed application form and application fee must be received by the board to meet the deadline. *The remainder of the items are needed at least three weeks prior to the board meeting.*



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PHYSICIAN FACT SHEET

LICENSURE ELIGIBILITY
Applicants must make a personal appearance before a Board representative prior to issuance of a permanent license. Applicants must show good moral character and must not be under license suspension or revocation by the licensing board in which the misconduct occurred.

Domestic Graduate Requirements
1. Graduate of an accredited medical or osteopathic school located in the United States, its territories, or Canada.
2. Successfully complete one year of U.S./Canadian graduate, clinical medical training in a program accredited by the Accreditation Council of Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) or the Royal College of Physicians & Surgeons of Canada, or other graduate training approved, in advance, by the board as meeting standards similar to those of a national accrediting organization.
3. Successfully complete the USMLE, National Board, LMCC, FLEX or state exam. Applicants licensed in another state must pass the SPEX exam within three attempts if it has been more than 10 years since taking the initial licensing exam unless currently certified by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association Bureau of Professional Education, of the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada.

International Graduate Requirements
1. Graduate of a medical school listed in the World Directory of Medical Schools.
2. Successfully complete two years of US/Canadian graduate, clinical medical training in an accredited program unless 1) admitted as a permanent immigrant to the United States as a person of exceptional ability in sciences pursuant to rules of the U.S. Department of Labor or 2) issued a permanent immigrant visa as a person of extraordinary ability or as an outstanding professor or researcher and has a valid medical license in another country; or 3) licensed in another state and practiced 5 years without disciplinary action in the US/Canada, completed one year US/Canadian accredited training and passed SPEX within three attempts in 24 months prior to licensing.
3. ECFMG certificate.
4. Successfully complete the USMLE, FLEX, LMCC or state exam. Applicants licensed in another state must pass the SPEX exam within three attempts if it has been more than 10 years since taking the initial licensing exam unless currently certified by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association Bureau of Professional Education, of the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada.

USMLE REQUIREMENTS
Applicants must have passed steps 1, 2 and 3 within three attempts. Four attempts are allowed if currently licensed in another state and currently certified by a specialty board of ABMS, AOABPE, RCPSC, or CFPC. USMLE Step 3 must be passed within 5 years of Step 2 or before the end of residency training. Applicants must pass each step with passing scores as recommended by the USMLE program. Combinations of FLEX, National Board, and USMLE (as outlined in the USMLE bulletin) may be accepted by the Board as comparable to existing exam sequences, but all exams must be passed within three attempts and completed prior to the year 2000.

FLEX EXAM REQUIREMENTS

Eligibility requirements for medical licensure in Minnesota based on the FLEX exam are as follows:
1. Applicants who took and passed FLEX prior to 1985 must have passed in one sitting within five attempts.
2. Applicants who took and passed FLEX between 1985 and 1990 may pass in two sittings providing it is within five attempts.

3. Applicants who have made up to five attempts to pass FLEX (some attempts before 1985 and some between 1985 and 1990, inclusive) may pass in two sittings between 1985 and 1990.
4. Applicants taking FLEX after 1990 may pass in two sittings within three attempts.

The latest score is the "official score". Passing score is a weighted average of 75 prior to 1985; thereafter, the passing score is 75 on each component.

PERMITS
A temporary permit is available for physicians who have complied with all requirements and wish to practice prior to a decision on their application. A temporary permit is valid only until the Board meeting at which a decision is made on the application. No extension is available. Physicians licensed in another state who have complied with all other requirements, but have not yet passed SPEX, may receive a temporary permit valid for up to six months.

A physician must have a residency permit to participate in a residency program unless licensed by the Board. The residency permit is program specific; therefore, a separate residency permit is required for each residency program until a physician is licensed.

LICENSURE EXEMPTIONS
Minnesota does not require the following physicians to be licensed while:

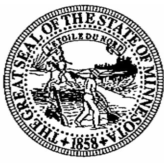
1. practicing at a federal facility providing s/he is licensed elsewhere.
2 in actual consultation here providing s/he is licensed in another state or country.
3. serving as a camp doctor in Minnesota; however, physicians must register with the board. There is no fee involved.
4. a student practicing under the direct supervision of a preceptor and attending a recognized medical school.

5. performing the duties of an intern or resident or engaged in postgraduate work approved by the board as meeting standards similar to those of a national accrediting organization provided the student has a residency permit issued by the Board.
6. employed in a scientific, sanitary or teaching capacity by a bona fide educational institution or state health department while engaged in such duties.
7. providing medical services at a competitive athletic event if physician is registered with the Board and is licensed in another state.

CONTINUING MEDICAL EDUCATION
Each licensed physician must obtain 75 hours of continuing medical education (CME) category 1 credit every three years as a condition of licensure renewal. Newly licensed physicians commence their three year cycle on their birth month following the initial date of licensure. Physicians under Emeritus registration and licensees in full-time residency or fellowship training at a professionally accredited facility are exempt from the continuing medical education requirement.

RENEWAL CYCLE
Medical licenses must be renewed annually based on birth month. Renewal notices are sent approximately 45 days prior to expiration. It is the physician's responsibility to keep the Board advised of their current address. The Board is obligated to mail the renewal information to the address on file. Failure to receive the renewal information does not relieve physicians of their renewal obligation. Physicians practicing in Minnesota without a currently valid license are practicing illegally which may result in potential liability or disciplinary action. Physicians not practicing in Minnesota who allow their license to lapse are cancelled after two years due to nonrenewal and must reapply and meet the requirements in place at the time in order to resume practice in Minnesota.

If any part of this Fact Sheet conflicts with the rules or laws, the rules or laws take precedence. It is your responsibility to comply. Ignorance of the law is not a defense. Call Board offices with any questions.



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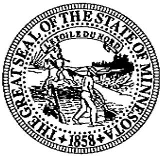
NOTICE

In accordance with Minnesota Statute 147.091, the Board may deny an application or grant a restricted license based on the following conduct:

a. Failure to demonstrate qualifications or satisfy licensure requirements.
b. Obtaining a license by fraud or cheating, or attempting to subvert the licensing examination process.
c. Conviction, during the previous five years, of a felony reasonably related to the practice of medicine.
d. Revocation, suspension, restriction, limitation, or other disciplinary action against the person's medical license in another state or jurisdiction, failure to report to the board that charges regarding the person's license have been brought in another state or jurisdiction, or having been refused a license by any other state or jurisdiction.
e. False or misleading advertising.
f. Violating a rule promulgated by the board or an order of the board, a state, or federal law which relates to the practice of medicine or a state or federal narcotics or controlled substance law.
g. Engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare or safety of a patient; or medical practice which is professionally incompetent.
h. Failure to supervise a physician's assistant or failure to supervise a physician under any agreement with the board.
i. Aiding or abetting an unlicensed person in practice of medicine.
j. Adjudication as mentally incompetent, mentally ill or mentally retarded, or as a chemically dependent person, a person dangerous to the public, or a person who has psychopathic personality by a court of competent jurisdiction.
k. Engaging in unprofessional conduct including any departure from or the failure to conform to the minimal standards of acceptable and prevailing medical practice.
l. Inability to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills.
m. Revealing a privileges communication from or relating to a patient except when otherwise required or permitted by law.
n. Failure by a doctor of osteopathy to identify the school of healing.
o. Improper management of medical records.
p. Fee splitting.
q. Engaging in abusive or fraudulent billing practices.
r. Becoming addicted or habituated to a drug or intoxicant.
s. Prescribing a drug or device for other than medically accepted therapeutic purposes.
t. Inappropriate sexual conduct.
u. Failure to fulfill reporting obligation.
v. Knowingly providing false or misleading information directly related to the care of a patient unless done for accepted therapeutic purposes; e.g. administration of a placebo.
w. Aiding suicide or aiding attempted suicide.
x. Practicing under lapsed or nonrenewed credentials.
y. Failure to repay a state or federal secured student loan in accordance with loan provisions.

The Board may not grant a license to practice medicine to any person who has been convicted of a felony-level criminal sexual conduct offense. “Conviction” means a plea of guilty, a verdict of guilty by a jury, or a finding of guilty by the court and “criminal sexual conduct offense” means a violation of section 609.342 to 609.345 or a similar statute in another jurisdiction.

The Board will closely examine any application where applicant has been disciplined in another state. Applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.



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INSTRUCTIONS

Enclosed is your application for a Minnesota medical license. Please thoroughly review the enclosed materials before submitting your application. **Do NOT make commitments to start practicing medicine in Minnesota until you have been issued a license.** Any processing fees incurred are your responsibility. The Board reserves the right to reject any outdated applications submitted; therefore, it is recommended that you use the application in a timely manner. Incomplete applications will be destroyed after six months of inactivity.

ALL OF THE FOLLOWING REQUIREMENTS MUST BE MET OR THE ENTIRE APPLICATION WILL BE RETURNED.

1. Fee of $392 ($200 processing fee and $192 annual registration fee). The $60 temporary permit fee, if requested. *These fees are not refundable and must be in U.S. currency.* Make checks payable to the **Minnesota Board of Medical Practice.**
2. All your time must be accounted for on the application, from high school to the date of application. If exact dates are unknown, you may include only month and year. During continuous years of education, periods of three months or less (summer break) need not be accounted for. List as practice references any facility where you are being paid outside the internship or residency program even if you are practicing at the same facility.
3. The name on the application and medical diploma must be the same. If there has been a name change, submit a *notarized* copy of the documentation, e.g. marriage certificate.
4. A full face, recent, 2x3" photograph must be affixed as indicated on the application and *notarized* next to the picture as a true likeness. The notary seal must fall partly upon the photograph and partly upon the application.
5. **US/Canadian graduates only.** Copy of medical diploma and copy of 1st year post graduate training certificate, if issued.
6. **International medical graduates only**. Copies of the following original documents with certified translations (originals will be reviewed at your personal appearance):
   A. Birth record/passport
   B. Medical diploma
   C. Foreign internship certificate
   D. Foreign licenses and practice certificates
   E. U.S./Canadian post-graduate certificates
   F. ECFMG certificate
7. *Notarized* copy of military discharge papers (DD Form 214), if applicable.
8. Completed, signed, dated **MALPRACTICE HISTORY REPORT** form, even if not applicable. For each malpractice suit in which you have been named, you must include a detailed clinical explanation of the situation and insurance papers or other formal documentation of the outcome/status.
9. Completed, signed, dated **FACILITIES LIST** form, even if not applicable.

THE FOLLOWING REQUIREMENTS MUST BE SENT DIRECTLY TO THE MINNESOTA BOARD FROM THE FACILITY/PERSON COMPLETING THE FORM:

NOTE: *Applicants may use the Federation Credentialing Verification Service (FCVS) when applying for Minnesota medical licensure. The FCVS verifies USMLE, NBME and FLEX exam scores, ECFMG certification, medical education and all U.S./Canadian medical training. The FCVS contact telephone number is 888-275-3287 or if you have questions regarding your application their website is www.fsmb.org. Please disregard these verification forms in your application materials.*

1. **All verification forms.** These forms must be submitted before your application is complete. It is your responsibility to make sure these forms are completed and received by our office. The Board must receive separate verification forms completed by medical schools attended, all post graduate internship, residency, fellowship, research or other medical training programs, specialty boards, each hospital where you have held privileges outside a postgraduate training program during the last ten years, each state board where you have held a medical license and recommendations from two of the physicians you named as references during your last five years of practice who can testify to your character, personal reputation, background, and

professional ability. A verification must be received from every board issuing any type of license to you including training, locum tenens, and temporary permit. Make photocopies or download forms as necessary. Verifications through VeriDoc are also accepted. Log on to www.veridoc.org and follow the onscreen instructions.

2. **National Practitioner Data Bank/Health Integrity and Protection Data Bank (NPDB/HIPDB) reports.** Download the Self-Query form from the NPDB/HIPDB website at www.npdb-hipdb.hrsa.gov under "Self-Query". Complete the required information and send to the NPDB/HIPDB as instructed. The response will be mailed directly to **YOU**. Upon receipt submit a **notarized** copy of the **ENTIRE** packet or the **unopened** envelope you received to the Board office. The packet should contain **BOTH** the **NPDB** and the **HIPDB** query responses.
3. **Examination scores.** See following instructions.
4. **Educational Commission for Foreign Medical Graduates (ECFMG) verification.** (international medical graduates only) Log on to www.ecfmg.org/cvs/index.html for the request form or to submit the request online. Confirmations are sent directly to the Board.

FOLLOW THESE INSTRUCTIONS FOR THE TYPE OF EXAMINATION PASSED (THE MINNESOTA BOARD MUST RECEIVE THE SCORES DIRECTLY FROM THE NATIONAL BOARDS, FEDERATION, STATE BOARD OR MEDICAL COUNCIL OF CANADA OR FCVS):

1. **National Board of Medical Examiners (NBME).** Download "Request for Endorsement of NBME Certification Form" available in the Programs and Services section of NBME website at www.nbme.org OR send a signed written request which includes the state to which you are applying, your name (please print), USMLE or NBME ID# or SS#, your date of birth, current address, phone # and your e-mail address. Check website for current fee information. If you require additional information, please call the Examinee Records office at (215)590-9592.
2. **National Board of Osteopathic Medical Examiners (NBOME).** Download "Transcript Request Form" from NBOME website at www.nbome.com OR submit a written request including a) full name; b) National Board ID# (if known); c) osteopathic medical school and date of graduation; d) name and address of the Minnesota Board; and e) check website for current fee information. Mail or fax to: National Board of Osteopathic Medical Examiners, 8765 W. Higgins Rd. Ste. 200, Chicago, IL 60631-4101. Phone: 773-714-0622, Fax: 773-714-0631.
3. **United States Medical Licensing Examination (USMLE) or Federation Licensing Examination (FLEX).** The Examination and Board Action History Report (EBAHR) is to be downloaded from the Federation of State Medical Board's website at www.fsmb.org under "Examination Services" then "Transcripts". Check website for current fee and processing information. Physicians who have not taken USMLE Step 3 should wait until Step 3 has been passed to ensure the score report includes Step 3. Phone: 817-868-4041.
4. **Exam Combinations (FLEX, NBME, USMLE).** Contact the National Board and/or the Federation for the release of your scores.
5. **State Examination.** Contact the State Board where you took your examination and have them send your scores directly to us. There may be a fee required.
6. **Medical Council of Canada (LMCC).** Download the "Statement of Registration" request from the MCC website at www.mcc.ca or mail a request to: Medical Council of Canada, 100-2283 St. Laurent Blvd., PO Box 8234 STN T, Ottawa, ON K1G 3H7, Canada. Check website for current fee information.
7. **SPEX Examination.** You are required to pass the SPEX examination within 3 attempts if you have not passed any of the licensing examinations listed above during the last 10 years and you are not currently certified by the American Board of Medical Specialists, American Osteopathic Association Bureau of Professional Education, Royal College of Physicians and Surgeons of Canada or College of Family Physicians of Canada. The examination is a computer-based exam administered by the Federation of State Medical Boards through Prometric Centers.
   - A. If you have taken SPEX in another state download the Examination and Board Action History Report (EBAHR) from the Federation of State Medical Board's website at www.fsmb.org under "Transcript Requests". There is a processing fee involved.
   - B. If applying to take the SPEX exam download the application from the Federation of State Medical Board's website at www.fsmb.org under "Post-Licensure Assessment" then click on "Special Purpose Exam (SPEX)".

BOARD MEETINGS AND DEADLINES

Upon receipt of your application, you will be put on the next Board agenda unless you specify a particular Board. It is your responsibility to make sure your file is complete; i.e. verifications, completed application, recommendations, exam scores, and documentation have been received by our Board. Applicants with incomplete files will not be put on the Board agenda. The Board generally meets the second Saturday on odd-numbered months. Applications and fees must be received by the deadline dates noted on the attached form. As a rule, interviews must be completed by the third Friday of the month preceding the Board meeting.

USMLE EXAMINATION ADMINISTRATION

Applicants are eligible to take the United States Medical Licensing Exam (USMLE) Step 3 providing the following requirements are met by the Step 3 examination date: a) MD (or equivalent) or DO degree has been conferred; b) notice of successful completion of USMLE Step 1 and Step 2 within three attempts has been received; c) be currently enrolled in or completed a post graduate training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), College of Family Physicians of Canada (CFPC), or the Royal College of Physicians and Surgeons of Canada (RCPSC). The USMLE Step 3 must be passed within five years of Step 2 or before the end of residency training. The Minnesota Board of Medical Practice has contracted with the Federation of State Medical Boards to provide application processing and test administration services. The Federation has established an Examination/Registration Hotline (817)735-0722 or apply on line/download forms at www.fsmb.org. Eligibility to sit for USMLE Step 3 does not signify eligibility for a license to practice medicine and surgery in Minnesota. The licensure application process is separate from the exam application process.

TEMPORARY PERMIT

A temporary permit is available for physicians who have applied for licensure, submitted all fees and complied with all requirements and wish to practice prior to the next regularly scheduled Board meeting. The temporary permit is valid only until the next Board meeting at which a decision is made on the application for licensure.

Applicants who are required to sit for the SPEX exam may be issued a temporary permit for up to 6 months once their application is complete and we have received confirmation from Prometric that the applicant is registered for an exam date or a copy of the SPEX certificate of completion.

The statute requires that all applicants must make a personal appearance before a Board representative at least two weeks prior to the Board meeting at which you will be considered for a license. An interview will be scheduled at a later date with written notice sent to each applicant. Each applicant must submit written notification to the Board within 30 days of any name or address change.

APPLICATION TO PRACTICE MEDICINE

MINNESOTA BOARD OF MEDICAL PRACTICE
UNIVERSITY PARK PLAZA
2829 UNIVERSITY AVENUE SE, SUITE 500
MINNEAPOLIS, MINNESOTA 55414-3246
612-617-2130 or www.bmp.state.mn.us

Hearing Impaired-Minnesota Relay Service
Metro Area 297-5353
Outside Metro Area 1-800-627-3529

FOR BOARD USE ONLY

APPLICATION #: ________
CHECK/RECEIPT #: ________
AMT PAID: ________
TEMP PERMIT #: ________
BOARD ACTION: ________
BOARD DATE: ________
LICENSE #: ________

SOURCE CODE	AMOUNT
5200 lic	
5201 app	
5203 tp	

DATE OF APPLICATION:

MONTH	DAY	YEAR

INSTRUCTIONS TO APPLICANT

1. Answer all questions completely, accurately, and legibly or the application will be returned.
2. The name you enter must exactly match the name on your medical diploma, or documentation of formal name change must be submitted.
3. All addresses must include zip code if requested on the application.
4. Account for all time from the beginning of high school, whether spent in school, practice, or otherwise. Dates must include Month, Day, and Year. Attach a separate sheet if necessary.
5. Enter all dates as MONTH-DAY-YEAR.
6. The application fee is not refundable.
7. Failure to answer all questions completely and accurately, omission or falsification of material facts, alteration of application may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.
8. Incomplete applications may be destroyed after six months of inactivity.

TO: The Minnesota Board of Medical Practice:

I hereby make application for a license to practice medicine and surgery in the State Of Minnesota and submit the following statement concerning my age, moral character, preliminary and medical education and practice.

YOUR CURRENT NAME AND ADDRESS

FULL LEGAL NAME: LAST	FIRST		MIDDLE
STREET ADDRESS:			
CITY:	STATE OR PROVINCE:	ZIP CODE:	COUNTRY:
HOME PHONE:	OTHER PHONE:	OTHER NAMES:	
SOCIAL SECURITY OR ALIEN REGISTRATION NUMBER:		GENDER ☐ MALE ☐ FEMALE	

BASIS FOR APPLICATION (CHECK ONE)

- ☐ FEDERATION LICENSING EXAMINATION (FLEX)
- ☐ NATIONAL BOARD OF MEDICAL EXAMINERS EXAMINATION (NBME)
- ☐ NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS EXAMINATION (NBOME)
- ☐ COMPREHENSIVE OSTEOPATHIC MEDICAL LICENSING EXAMINATION (COMLEX-USA)
- ☐ LICENTIATE OF MEDICAL COUNCIL OF CANADA EXAMINATION (LMCC)
- ☐ STATE BOARD EXAMINATION (STATE)
- ☐ UNITED STATES MEDICAL LICENSING EXAM (USMLE)
- ☐ COMBINATION FLEX, NBME, USMLE (MUST BE COMPLETED BY YEAR 2000)

ECFMG CERTIFICATION (FOREIGN ONLY)

NUMBER:

DATE ISSUED:

DRIVER'S LICENSE

STATE:

NUMBER:

ADDRESS OF NEAREST RELATIVE		
NAME OF RELATIVE:		
STREET ADDRESS:		
CITY:		STATE OR PROVINCE:
ZIP CODE:	COUNTRY:	RELATIONSHIP:

YOUR INTENDED ADDRESS (IF KNOWN)		
STREET ADDRESS:		
CITY:		STATE OR PROVINCE:
ZIP CODE:	COUNTRY:	EFFECTIVE DATE:
PHONE:		

RECORD OF BIRTH			
BIRTHDATE (MO/DAY/YEAR) / /	CITY OF BIRTH:	COUNTY OF BIRTH:	STATE/PROVINCE OF BIRTH:
FULL NAME OF FATHER:		MOTHER'S MADEN NAME:	COUNTRY OF BIRTH:

IDENTIFYING CHARACTERISTICS			
HEIGHT (ft./in.):	WEIGHT (lbs):	COLOR HAIR:	COLOR EYES:
IDENTIFYING MARKS:			

PRELIMINARY EDUCATION					
NAME OF HIGH SCHOOL:	CITY:	STATE OR PROVINCE:		FROM DATE: (Mo/Day/Year) / /	TO DATE: (Mo/Day/Year) / /
NAME OF COLLEGE:	CITY:	STATE OR PROVINCE:	DEGREE	FROM DATE: (Mo/Day/Year) / /	TO DATE: (Mo/Day/Year) / /
NAME OF COLLEGE:	CITY:	STATE OR PROVINCE:	DEGREE	FROM DATE: (Mo/Day/Year) / /	TO DATE: (Mo/Day/Year) / /

MEDICAL EDUCATION (MEDICAL COLLEGES MUST BE RECOGNIZED BY THE BOARD)					
INSTITUTION	CITY	STATE	ZIP CODE	FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)

ACCOUNTING OF TIME NOT NOTED ELSEWHERE ON THIS APPLICATION		
ACTIVITY (ATTACH SEPARATE SHEET, IF NECESSARY)	FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)

MEDICAL DIPLOMAS

BACHELOR OF:	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE	ZIP:	COUNTRY:	DATE Mo/Day/Year
❑ MEDICINE ❑ OSTEOPATHY						
DOCTOR OF OF:	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE	ZIP:	COUNTRY:	DATE Mo/Day/Year
❑ MEDICINE ❑ OSTEOPATHY						

US/CANADIAN ACCREDITED GRADUATE CLINICAL MEDICAL INTERNSHIP, RESIDENCY, FELLOWSHIP

NAME OF HOSPITAL:		FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
TYPE OF TRAINING: (BE SPECIFIC)				
NAME OF HOSPITAL:		FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
TYPE OF TRAINING: (BE SPECIFIC)				
NAME OF HOSPITAL:		FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
TYPE OF TRAINING: (BE SPECIFIC)				
NAME OF HOSPITAL:		FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
TYPE OF TRAINING: (BE SPECIFIC)				
NAME OF HOSPITAL:		FROM DATE (Mo/Day/Year)	TO DATE (Mo/Day/Year)	
STREET ADDRESS:	CITY:	STATE OR PROVINCE:	COUNTRY:	ZIP CODE:
TYPE OF TRAINING: (BE SPECIFIC)				

MILITARY SERVICE

BRANCH OF SERVICE:	ENTRY DATE (Mo/Day/Year)	RELEASE DATE (Mo/Day/Year)	RANK AT DISCHARGE:	TYPE OF DISCHARGE
DUTY ASSIGNMENT:			LOCATION:	

STATES/PROVINCES/COUNTRIES IN WHICH YOU ARE OR HAVE EVER BEEN LICENSED

STATE/PROVINCE/COUNTRY	LICENSE NUMBER	DATE ISSUED (Mo/Day/Year)	HOW OBTAINED(*)

(*) NATIONAL BOARD OF MEDICAL EXAMINERS (NBME)
STATE BOARD EXAM (STATE)
NATIONAL BOARD OF OSTEO MEDICAL EXAMINERS (NBOME)
COMPREHENSIVE OSTEO MEDICAL LICENSING EXAM (COMLEX-USA)
FLEX EXAMINATION (FLEX)
UNITED STATES MEDICAL LICENSING EXAM (USMLE)
COMBINATION FLEX, NBME, USMLE (COMB)
LICENTIATE OF MEDICAL COUNCIL OF CANADA (LMCC)

PRACTICE REFERENCES

STATE BELOW WHERE YOU HAVE PRACTICED OUTSIDE OF A TRAINING PROGRAM, AND LIST TWO REFERENCES FROM EACH FACILITY

NAME OF FACILITY:	FROM DATE (MONTH/DAY/YEAR)	TO DATE (MONTH/DAY/YEAR)		
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:

NAME OF FACILITY:	FROM DATE (MONTH/DAY/YEAR)	TO DATE (MONTH/DAY/YEAR)		
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:

NAME OF FACILITY:	FROM DATE (MONTH/DAY/YEAR)	TO DATE (MONTH/DAY/YEAR)		
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NAME OF FACILITY:	FROM DATE (MONTH/DAY/YEAR)	TO DATE (MONTH/DAY/YEAR)		
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATECNTRY	ZIP CODE:

NAME OF FACILITY:	FROM DATE (MONTH/DAY/YEAR)	TO DATE (MONTH/DAY/YEAR)		
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATE/CNTRY	ZIP CODE:
NAME OF REFERENCE	STREET ADDRESS:	CITY:	STATECNTRY	ZIP CODE:

PROPOSED PRACTICE PLANS IN MINNESOTA (IF ANY)

MEMBERSHIP IN PROFESSIONAL SOCIETIES AND ORGANIZATIONS

NAME OF ORGANIZATION	FROM DATE	TO DATE

Are you currently* certified by a specialty board of the (check one):

- ❑ American Board of Medical Specialties
- ❑ Royal College of Physicians and Surgeons of Canada
- ❑ College of Family Physicians of Canada
- ❑ American Osteopathic Assn Bureau of Professional Education
- ❑ None of the above

Specialty: ____________________

Issue Date: ____________________

Expiration Date: ____________________

* If it has been more than 10 years since your initial licensing exam, the SPEX exam is required unless currently specialty board certified.

Except for questions 1-4, please answer all questions by selecting Yes or No and provide an explanation when requested. Questions 1-4 do not have “No” as an option for confidentiality reasons. If you have a condition addressed by questions 1-4 and you are NOT participating in Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer “Yes” to the applicable questions(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s). For questions 1-2, the terms “impaired” and “limited” include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders or conditions, or chemical dependency or chemical abuse. The purpose and intended us of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your application is pending and public after your renewal is granted. Exception: “Yes” answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling. If responses to questions change during the time your application is pending, you must make the board aware of the new information.

Y	1. Is your cognitive, communicative, or physical capability to engage in the practice of medicine or surgery with reasonable skill and safety impaired or limited in any way? Please describe.
	Y N 1a. If yes, are the limitations or impairments reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe.
	Y N 1b. If yes, are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe.
Y	2. Does your use of alcohol or chemical substance(s), including prescription medications, in any way impair or limit your ability to practice medicine with reasonable skill and safety? Please describe.
Y	3. Are you engaged in any illegal use of controlled substances including use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider). Please describe.
	Y N 3a. If yes, have you taken any steps (i.e. treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe.
	Y N 3b. If yes, are you now participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe.
Y	4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety? If you answer this question 'yes", please answer the following:
	Y N 4a. With regard to any condition referenced above, are you being treated so that such impairment is avoided?
	Y N 4b. With regard to any condition referenced above, are you in compliance with the recommended treatment?
	Y N 4c. With regard to any condition referenced above, has your treating physician advised you that you are able to practice medicine with reasonable skill and safety?
	4d. Please explain.____
	4e. Identify your treating physician.________________________________
Y N	5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? Please describe.

Y N	6. Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars. ____________
Y N	7. Have you ever been denied a license, or the privilege of taking an examination before any medical examining board, or has a conditioned license been issued to you by any state medical board or licensing authority? If so, give particulars. ____________
Y N	8. Has your license to practice medicine in any state or country been voluntarily or involuntarily (i.e. by Medical Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a Medical Board or other licensing authority? If so, give particulars. ____________
Y N	9. Have you ever been notified of any investigations by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you been reprimanded or censured by any medical society or licensing board? If so, give particulars. ____________
Y N	10. Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, give a detailed clinical explanation of each case as well as documentation of outcome (insurance papers or court documents).
Y N	11. Have your hospital privileges been restricted or revoked? If so, give particulars. ____________
Y N	12. Have there ever been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, give particulars including the date of conduct, state and local jurisdiction in which the charges were filed. ____________
Y N	13. Have there ever been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemicals filed against you? If so, give particulars, including the date of conduct, state and local jurisdiction in which the charges were filed. ____________ ____________
Y N	14. Have you ever voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances? If so, give particulars. ____________
Y N	15. Have you ever applied for licensure in Minnesota before? If so, please give license # and issue date or withdrawal/denial date. ____________
Y N	16. Have you ever had a residency permit in Minnesota? If so, please give residency permit number. (Residents are required to have residency permits as of 1993 unless licensed in Minnesota). ____________

CERTIFICATE OF ETHICAL AND MORAL CHARACTER

THIS CERTIFICATE MUST BE SIGNED BY TWO LICENSED PHYSICIANS WHO ARE PERSONALLY ACQUAINTED WITH THE APPLICANT.

I certify that the photograph attached is a recent one and likeness of Dr. ________________________________

And that s/he is a person of good ethical and moral character.

________________________	____________	____________	____________
SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE

____
PRINT OR TYPE FULL NAME

CERTIFICATION OF IDENTIFICATION
Certification of Notary Public is required.

State:________________________ County:________________________

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. Sworn to before me by the applicant on this _______ day of ______________ , _____________.

Notary Public Signature ____________________________________

Expiration Date _____ / _____ / _____
Month Day Year

____
Applicant Signature

I certify that the photograph attached is a recent one and likeness of Dr. ________________________________

And that s/he is a person of good ethical and moral character.

________________________	____________	____________	____________
SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE

____
PRINT OR TYPE FULL NAME

AFFIDAVIT OF APPLICANT:

STATE OF: ____________________

COUNTY OF: ____________________

I, ____, swear that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of Minnesota: that I am the person named in the diploma, which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, my references, personal physicians, employers (past and present), business and professional associates (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for licensure in Minnesota.

I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing of oral information or of documents, records, or other information to the Board.

I have carefully read the questions in the in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine in Minnesota. I understand that I am required to update my application with pertinent information to cover the time period between date of application and date approved by the Board.

Sworn to before me this _______ day of ________, ________.

____

Signature of Notary Public

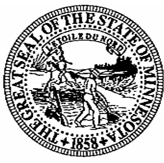
My Commission Expires: ________________

____

Signature of Applicant

RIGHTS OF SUBJECTS OF DATA

This information is requested by the Minnesota Board of Medical Practice. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. The information is classified as private while your application is pending or if your application is denied, and as public if your license is granted. You are required to submit this information. Your application will not be processed without it and the form will be returned to you for completion. This information may be used as the basis for further investigation by the Board into your qualifications. Under some circumstances, the information could become available to other agencies or persons authorized by law to have access. Attach a separate page for detailed explanations, when appropriate. Failure to answer all questions completely and accurately, omission or falsification of material facts, alteration of application may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.



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CERTIFICATION OF MEDICAL EDUCATION

This form is for certification of medical education and must be completed and mailed by the facility directly to the **Minnesota Board of Medical Practice**. Any processing fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name ____ SS# ______________________

Signature ____ Date ______________________

Date of Degree ________________________________ Degree Received ______________________

- -

THE SCHOOL COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician) ____

MATRICULATED IN:(Name of School)____

AT:(Location of School)____

AND RECEIVED A DIPLOMA CONFERRING:(Degree)______________________________________

ON:(Month, Day, Year)____

ANY DISCIPLINARY ACTION? Yes*_______ No _______
(N/A is not an acceptable response)

ANY DEROGATORY INFORMATION ON FILE? Yes* _______ No _______
(N/A is not an acceptable response)

President, Secretary, Dean, Registrar:

School Seal**

Print Name________________________________

Signature_________________________________

Date_____________________________________

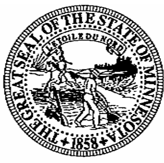
Phone Number______________________________

Fax Number________________________________

*Please attach letter of explanation.

**If there is no school seal, attach letter of explanation on letterhead.

01/02



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CERTIFICATION OF MEDICAL TRAINING

This form is for certification of all US/Canadian post graduate medical training (i.e. internship, residency and fellowship) and must be completed and mailed by the facility directly to the **Minnesota Board of Medical Practice**. Any processing fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name____ SS#______________

Signature ____ Date______________

Training Dates (Month,Day,Year)_________________________Birthdate__________________

- -

THE HOSPITAL OR INSTITUTION COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT:(Name of Physician)______________________________________

SERVED # OF YEARS IN POST GRADUATE TRAINING:(Number of Years)____________________

AT:(Name of Hospital or Institution)____

LOCATED AT:(Address)____

FROM:(Month,Day,Year)______________________________**TO:** (Month,Day,Year)______________________

ANY DISCIPLINARY ACTION? Yes*_______ No _______

ANY DEROGATORY INFORMATION ON FILE? Yes* _______ No _______

WAS/WAS NOT (CIRCLE ONE) **ISSUED A CERTIFICATE AS PROOF OF COMPLETION OF SAID TRAINING.** (if not issued certificate, please explain)

____

THE TRAINING PROGRAM WAS/WAS NOT (CIRCLE ONE) **COMPLETED. IF TRAINING PROGRAM WAS NOT COMPLETED, UNDER WHAT CIRCUMSTANCES DID THE PHYSICIAN LEAVE**?

____

THIS PHYSICIAN WAS PLACED IN A RESIDENCY SLOT IN AN ACCREDITED TRAINING PROGRAM TO PROVIDE GRADUATE, CLINICAL MEDICAL TRAINING DURING THE DATES OUTLINED ABOVE. (CHECK ONLY ONE)

_____**Accreditation Council of Graduate Medical Education (ACGME)**
_____**American Osteopathic Association (AOA)**
_____**Royal College of Physicians and Surgeons**
_____**College of Family Physicians of Canada**
_____**None of the above** (EXPLAIN)______________________________

Print Name_____________________________

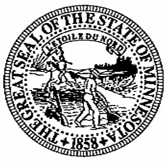
Signature______________________________

SEAL** Title__________________________________

Date__________________________________

Phone_______________ Fax______________

*Please attach letter of explanation.
**If there is no seal, attach letter of explanation on letterhead.



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VERIFICATION OF SPECIALTY BOARD CERTIFICATION

This form is for verification of specialty board certification for applicants who have not taken a licensing exam for 10 years. Applicants are required to pass the SPEX exam if it has been more than 10 years since taking the National Board, FLEX, LMCC, or state exam unless the applicant is currently certified by a specialty board of the American Board of Medical Specialties, the American Osteopathic Association Bureau of Professional Education, the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada. The form must be mailed directly by the specialty board (e.g. American Board of Internal Medicine, **not** American Board of Medical Specialties) to the **Minnesota Board of Medical Practice.** Any fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name____ SS#________________________

Signature____ Date______________________

- -

THE SPECIALTY BOARD COMPLETES THE FOLLOWING:

IT IS HEREBY CERTIFIED THAT: (Name of Physician)____

WAS ISSUED A CERTIFICATE ON: (Month, Day, Year)____

BY: (Name of Specialty Board)____

A SPECIALTY BOARD OF (CHECK ONLY ONE)**:**

_____**The American Board of Medical Specialties**
_____**The American Osteopathic Association/Bureau of Osteopathic Specialists**
_____**The Royal College of Physicians and Surgeons of Canada**
_____**The College of Family Physicians of Canada**

EXPIRATION DATE IS: (Month, Day, Year)____

SEAL*

Print Name__________________________

Signature___________________________

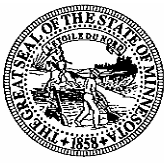
Title_______________________________

Date_______________________________

Phone______________________________

*If there is no seal, attach letter of explanation on letterhead.

05/03



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PHYSICIAN RECOMMENDATION FORM

This form must be completed and mailed directly to the **Minnesota Board of Medical Practice** by two US or Canadian licensed physicians with whom applicant has worked during the last five years, has known applicant for more than one year and who can testify to applicant's character, personal reputation, background and professional ability. This form does not have to be filled out by the same physicians you have listed on page 7 of the application. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name____

Signature________________________________ Date______________

- -

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Physician)______________________ __________

1. How long have you known the applicant?______________________________

2. What has been the nature of your relationship with the applicant?______________

   ____

3. How would you characterize the moral and professional conduct of the applicant?________

   ____

4. Would you recommend that the applicant be approved for licensure for the independent, unrestricted practice of medicine?______________________________

5. Circle the word(s) which best describes this applicant.

A.	Marginal*	Fully Meets Standards	A. Clinical skills
B.	Yes*	No	B. Any indication of chemical dependency?
C.	Yes*	No	C. Any indication of malprescribing?

Completed By:

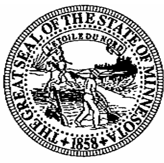
Print Name________________________________ Phone______________

Address____

Signature________________________________ Date______________

*Please attach letter of explanation.

01/02



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PHYSICIAN RECOMMENDATION FORM

This form must be completed and mailed directly to the **Minnesota Board of Medical Practice** by two US or Canadian licensed physicians with whom applicant has worked during the last five years, has known applicant for more than one year and who can testify to applicant's character, personal reputation, background and professional ability. This form does not have to be filled out by the same physicians you have listed on page 7 of the application. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name____

Signature_______________________________ Date_____________

- -

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Physician)___________________________ ____________

1. How long have you known the applicant?______________________________
2. What has been the nature of your relationship with the applicant?_________________

   ____

3. How would you characterize the moral and professional conduct of the applicant?________

   ____

4. Would you recommend that the applicant be approved for licensure for the independent, unrestricted practice of medicine?__________________________________
5. Circle the word(s) which best describes this applicant.

A.	Marginal*	Fully Meets Standards	A. Clinical skills
B.	Yes*	No	B. Any indication of chemical dependency?
C.	Yes*	No	C. Any indication of malprescribing?

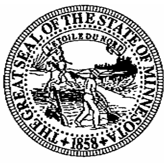
Completed By:

Print Name_______________________________ Phone_____________

Address____

Signature_______________________________ Date_____________

*Please attach letter of explanation.



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PHYSICIAN VERIFICATION OF LICENSURE

This form is for verification of all medical licenses from every U.S./Canadian board issuing any type of license including training, locum tenens, and temporary permit even if license is not current. Each Board completing the form must mail directly to the **Minnesota Board of Medical Practice**. Any fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name_______________________________ SS#_______________

Signature_______________________________ Date_______________

- -

THE STATE BOARD COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician)_______________________________

DATE OF BIRTH: (Month, Day, Year)_______________________________

WAS ISSUED LICENSE NUMBER:_______________________________

BY: (state)_______________ **ON:** (Month, Day, Year)_______________

EXPIRATION DATE: (Month, Day, Year) _______________________________

ISSUED ON THE BASIS OF: (Exam)_______________________________

DISCIPLINARY ACTION EVERY INITIATED, PENDING, OR INVOKED*: (Yes/No)_______________

EVER VOLUNTARILY RELINQUISHED MEDICAL LICENSE*: (Yes/No)_______________

ANY DEROGATORY INFORMATION WHICH YOU CAN RELEASE*: (Yes/No)_______________

Print Name_______________________

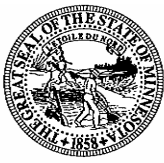
Signature_______________________

Title_______________________

Date_______________________

Phone_______________________

*If yes, please attach letter of explanation on letterhead. 1/02
**If there is no seal, attach letter of explanation on letterhead.
NOTE TO APPLICANT: Most states charge a fee for this service.



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FACILITIES LIST

Minnesota Statute 147.162 requires physicians to submit a list of inpatient and outpatient medical care facilities where you have medical privileges. In addition, the Board requests a list of all facilities where you have had medical privileges during the last 10 years. List any facility where you are getting (have been) paid outside a post graduate internship, residency or fellowship training program. Submit a Hospital Privilege Form to each facility listed except those clinics which are strictly outpatient. If you have had no privileges, write **NONE** and sign and date the form.

CURRENT PRIVILEGES

Facility	City and State	Type of Privilege

PAST PRIVILEGES (LAST 10 YEARS)

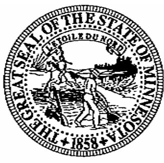
Facility	City and State	Type of Privilege

I hereby certify that the above is a true and accurate list of inpatient and outpatient facilities at which I have (have had) medical privileges.

Print Name____

Signature____ Date________________

01/02



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HOSPITAL PRIVILEGES VERIFICATION

As part of the medical license application process, the Minnesota Board of Medical Practice requires that this form be completed by each hospital where the applicant has held formal privileges within the last ten years. This form must be completed by each hospital listed on the Facilities List and mailed directly by each facility to the **Minnesota Board of Medical Practice**. Any processing fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name____ SS#_________________

Signature____ Date_________________

- -

THE HOSPITAL COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician)_______________________________________

HAD HOSPITAL PRIVILEGES AT: (Name of Hospital)_______________________________________

LOCATED AT: (Address)____

FROM: (Month, Day, Year)______________________**TO:** (Month, Day, Year)____________________

TYPE OF PRIVILEGE:____

ANY DISCIPLINARY ACTION? Yes*_______ No_______

ANY DEROGATORY INFORMATION ON FILE? Yes*_______ No_______

SEAL**

Print Name__________________________

Signature __________________________

Title ______________________________

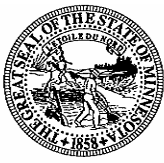
Date ______________________________

Phone______________________________

Fax _______________________________

*Please attach letter of explanation.
**If there is no seal, attach letter of explanation on letterhead.

01/02



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MALPRACTICE HISTORY REPORT

Minnesota Statute 147.035 requires that applicants previously practicing medicine in another state submit the following information for the last five years of active practice. For each malpractice suit in which you have been named, you must include a detailed clinical explanation of the situation and insurance papers or other formal documentation of the outcome/status.

NAME AND ADDRESS OF PROFESSIONAL LIABILITY INSURER IN OTHER STATE:

1.____

2.____

3.____

NUMBER, DATE, AND DISPOSITION OF ANY MEDICAL MALPRACTICE SETTLEMENT OR AWARD RELATING TO THE QUALITY OF MEDICAL TREATMENT:*

Number	Date	Disposition
________	________	______________________________
________	________	______________________________
________	________	______________________________
________	________	______________________________
________	________	______________________________

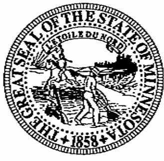
I hereby certify that the above is a true and accurate statement.

Print Name______________________________________

Signature______________________________________ Date______________

*If there has been no settlement or award, write **NONE**.

01/02



MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

TEMPORARY PERMIT APPLICATION

A temporary permit is available for physicians who have applied for permanent licensure and have complied with all requirements and wish to practice prior to the next regularly scheduled Board meeting. Upon request, a temporary permit will be issued after eligibility for licensure has been established and the credentialing and verification process has been completed. This process may take several weeks. The Board may, at it's discretion, issue a temporary permit under the above conditions. A temporary permit is valid only until the next Board meeting at which your application would be considered.

Applicants requesting a temporary permit must complete this form and submit a non-refundable $60 fee in U.S. currency. Please make checks payable to the **Minnesota Board of Medical Practice.**

NAME (Please print)____

TEMPORARY PERMIT WILL BE USED AT THE FOLLOWING PROPOSED PRACTICE LOCATION:

____
(Hospital/Clinic)

____
(Address)

____
(City, State, Zipcode)

PROFESSIONAL TELEPHONE NUMBER (including area code)____________________

ANTICIPATED DATE OF COMMENCING PRACTICE
AT PROPOSED PRACTICE LOCATION:____________________________

MAILING ADDRESS FOR TEMPORARY PERMIT:

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Submit two recommendation forms from physicians unless you have already done so. These forms must be sent directly to the Board.

11/96