



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

Treating Physician Statement

Applicant: Applicants who have a medical condition during the last five years which, if untreated, would be likely to impair their ability to practice with reasonable skill and safety must have their treating physician complete this form. A treating physician is the physician who diagnosed and provides or provided treatment for the condition and includes the current treating physician. **If not applicable, write "not applicable" on the form and submit with the application.**

Treating Physician: Complete and mail this form directly to the Minnesota Board of Medical Practice. This form is also available on our website.

Applicant's Printed Name _____

Applicant's Date of Birth (Mo/Day/Yr) _____ Health Profession _____

I hereby authorize you, my treating physician, to disclose my medical records to the Minnesota Board of Medical Practice. 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 oral information or documents, records, or other information to the Board.

Signed _____ Date _____

Nature of medical condition including diagnosis and significant symptoms

Date first saw patient: _____ Date last saw patient: _____

Has the applicant been compliant with treatment? (If no, please explain)

Yes No

What medications is the applicant taking for this condition?

If this medical condition was untreated, would it be likely to impair the applicant's ability to practice with reasonable skill and safety? (If yes, please explain) Yes No

Should the condition be monitored? (If yes, please explain) Yes No

Treating Physician (print name) _____

Signature _____ Date _____

Phone _____ Fax _____