

ATHLETIC TRAINER
Verification of Licensure/Registration/Certification

This form is for verification of all athletic trainer and other health care professional licenses or registrations from every jurisdiction issuing any type of license, registration or certification including training and temporary permit, even if license is not current. **Each Board completing the form must email or 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 this Board.**

Print Name _____ SS# _____

Signature _____ Date _____

THE STATE BOARD COMPLETES THE FOLLOWING INFORMATION:

It is hereby certified that: (Name of Applicant) _____

Date of birth: (Month, Day, Year) _____

Was issued license/registration number: _____

By: (State) _____ On: (Month, Day, Year) _____

Expiration date is: (Month, Day, Year) _____

Issued on basis of: (Exam) _____

Disciplinary action ever initiated, pending, or invoked*: Yes _____ No _____

Ever voluntarily relinquished license*: Yes _____ No _____

Seal**

Print Name _____

Signature _____

Date _____

Phone _____ Fax _____

*If yes, please attach letter of explanation.

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