

**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 \_\_\_\_\_

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**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 \_\_\_\_\_

School \_\_\_\_\_ Print Name \_\_\_\_\_

Seal\*\* \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

\*If yes, please attach letter of explanation.

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