MINNESOTA
BOARD OF MEDICAL PRACTICE

335 Randolph Avenue, Suite 140
St. Paul, MN 55102
612.617.2130 (phone) | 612.617.2166 (fax)
medical.board@state.mn.us | mn.gov/boards/medical-practice

CERTIFICATION OF MEDICAL EDUCATION

This form is for certification of medical education and **must be completed and emailed or 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 _____ Birthdate_____ Last 4 digits of SSN_____

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)

School
Seal**

President, Secretary, Dean, Registrar:

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.