MINNESOTA
HEALTH PROFESSIONALS
REGULATORY BOARDS

Administrative Services Unit
335 Randolph Avenue, Suite 103
St. Paul, MN 55102
Phone: 651-201-2732
Fax: 651-797-1381
asu.healthboards.hlb@state.mn.us

Volunteer Health Care Provider Program
Individual Registration or Renewal

PROGRAM YEAR 2025-2026 APPLICATION

INSTRUCTIONS FOR INDIVIDUAL VOLUNTEER REGISTRATION

1. **DO NOT APPLY** if you have malpractice liability insurance that will cover your volunteer services.
2. Submit this application to register as an individual volunteer provider to be eligible for liability coverage at a facility or organization registered under the Minnesota Volunteer Health Care Provider Program per Minnesota Statute 214.04.
3. Volunteers must be unpaid/uncompensated for services.
4. Eligible volunteer providers are limited to physicians, physician assistants, dentists, dental hygienists, dental therapists, advanced dental therapists, registered nurses, licensed practical nurses and advanced practice nurses.
5. You **must be** listed on the Volunteer Roster submitted by each registered facility or organization at which you provide volunteer health care services requiring liability coverage.
6. Answer all questions completely and accurately. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action by the individual licensing board if you are subsequently registered by ASU.
7. Applications may be emailed to asu.healthboards.hlb@state.mn.us or faxed to 651-797-1381 or mailed hard copy to Administrative Services Unit, 335 Randolph Avenue, Suite 103, St. Paul MN 55102.
8. Incomplete applications may be destroyed after six months of inactivity.
9. Applications for new individual registration are accepted at any time.
10. Renewal applications should be submitted prior to April 1st of each year to ensure continued liability coverage.
11. Registration expires annually April 30th.

Applicant Name: _____

For Office Use Only

License #: _____

Expiration Date: _____

Clinic ID: _____

Date Processed: _____

Mailed or Emailed

Section A: Volunteer Information

FIRST NAME	MIDDLE INITITAL	LAST NAME
STREET ADDRESS		
CITY	STATE	ZIP CODE
CELL PHONE	ALTERNATE PHONE	EMAIL ADDRESS
APPLICATION TYPE (check one) New Applicant Registration Renewal to Continue Insurance		
LICENSURE TYPE (check one)) Physician Nurse Practitioner Dentist Physician Assistant Registered Nurse Dental Hygienist Licensed Practical Nurse Dental Therapist or ADT		
BIRTH DATE (mm/dd/yyyy)	LICENSE NUMBER	LICENSED IN OTHER JURISDICTIONS (list)

Section B: Volunteer Locations

NAME OF REGISTERED FACILITY OR ORGANIZATION (1)		
STREET ADDRESS		
CITY	STATE	ZIP CODE
CONTACT PERSON AND TITLE		EMAIL ADDRESS
NAME OF REGISTERED FACILITY OR ORGANIZATION (2)		
STREET ADDRESS		
CITY	STATE	ZIP CODE
CONTACT PERSON AND TITLE		EMAIL ADDRESS

Section C: Volunteer Attestations

1. Are you currently covered by a medical professional liability insurance policy (self-insured or employer-provided) *that will provide coverage for your services at the volunteer location?* **If yes, you do not need to submit this application.**	Yes No
2. During the current Program Year (May 1, 2025 – April 30, 2026), how much volunteer time do you anticipate providing? Average # hours per month: _____ Average # hours per year: _____	
3. Do you agree to comply with risk management and loss prevention policies imposed by the insurer?	Yes No
4. Do you agree to receive no direct monetary compensation of any kind for services provided at the registered volunteer facilities/organizations?	Yes No
5. Is your current license free of restriction in all jurisdictions?	Yes No
6. Has any disciplinary action been taken against your license by a professional licensing authority or health care facility, including any voluntary surrender of license or other agreement involving the health care providers license to practice or any restrictions on practice, suspension of privileges, or other sanctions? *If yes, please attach an explanation.*	Yes No
7. Has any malpractice suit ever been filed against you? *If yes, please attach information outlining the origination of the suit and the final resolution.*	Yes No
8. Have you been named as a defendant in a lawsuit or had any claims been made against you with a previous or current insurer? *If yes, please attach dates, allegations, and disposition of each claim, or suit arising out of any occurrence within the last five years.*	Yes No
9. Do you have knowledge of any past activities or incidents that might give rise to a claim not yet presented? *If so, please attach an explanation.*	Yes No

Section D: Practice History

1. How long have you been practicing in health care or health-related service? _____

2. What is your current or most recent type of practice? (check one)

   Individual (Self-Employed)

   Partnership/Group Practice

   Professional Corporation

   Professional Association

   Fellow/Resident/Intern

   Other _____

3. Name all places where you have practiced your profession in the last five years:

Locations:	*During Years:*
_____	_____
_____	_____
_____	_____
_____	_____

Section E: Volunteer Agreement

I herein make application to be registered as an individual health care volunteer in the Minnesota Volunteer Health Care Provider Program at the facilities/organizations named in this application and registered with the Administrative Services Unit of the MN Health Professionals Regulatory Boards.

I agree that signing this application does not bind the state to complete the insurance. However, this application will be the basis of the contract should a policy be issued. I certify that reasonable inquiry has been made to obtain the answers given in this application and that information provided is correct and complete to the best of my knowledge.

Signature _____ Date (mm/dd/yyyy) _____