



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

MEDICAL FACULTY PHYSICIAN FACT SHEET

LICENSURE ELIGIBILITY

A personal appearance is no longer required for all applicants, but may be required for some applicants to resolve issues during the application review process. A notarized driver's license, legible with a clear photo is accepted in lieu of the personal appearance. Applicants must show good moral character and must not be under license suspension or revocation by the licensing board of the jurisdiction in which the misconduct occurred.

Medical Faculty Physician Requirements

1. Graduate of a medical school listed in the International Medical Education Directory (IMED).
2. Successfully complete two years of US/Canadian graduate, clinical medical training in an accredited program unless 1) admitted as a permanent immigrant to the United States as a person of exceptional ability in sciences pursuant to rules of the U.S. Department of Labor or 2) issued a permanent immigrant visa as a person of extraordinary ability or as an outstanding professor or researcher and has a valid medical license in another country; or 3) licensed in another state and practiced 5 years without disciplinary action in the US/Canada, completed one year US/Canadian accredited training and passed SPEX within three attempts in the 24 months prior to licensing. See Minn. Stat. §147.0375, Subd. 1, (c) for details.
3. Present evidence satisfactory to the Board that the applicant has been appointed to serve as a faculty member of a medical school accredited by the Liaison Committee of Medical Education or an osteopathic medical school accredited by the American Osteopathic Association.

LICENSURE EXEMPTIONS

Minnesota does not require the following physicians to be licensed while:

1. Practicing at a federal facility providing s/he is licensed elsewhere.
2. In actual consultation here providing s/he is licensed in another state or country.
3. Serving as a camp doctor in Minnesota; however, physicians must register with the board. There is no fee involved.
4. A student practicing under the direct supervision of a preceptor and attending a recognized medical school.
5. Performing the duties of an intern or resident or engaged in postgraduate work approved by the board as meeting standards similar to those of a national accrediting organization provided the student has a residency permit issued by the Board.
6. Employed in a scientific, sanitary or teaching capacity by a bona fide educational institution or state health department while engaged in such duties.
7. Providing medical services at a competitive athletic event if the physician is registered with the Board and is licensed in another state.

CONTINUING MEDICAL EDUCATION

Each licensed physician must obtain 75 hours of continuing medical education (CME) category 1 credit every three years as a condition of licensure renewal. The Board accepts (re)certification or current Maintenance of Competency issued by ABMS, RCPSC, CFPC or AOA in lieu of CME. Newly licensed physicians commence their three year cycle on their birth month following the initial date of licensure. Physicians under Emeritus registration and licensees in full-time residency or fellowship training at a professionally accredited facility are exempt from the continuing medical education requirement.

RENEWAL CYCLE

Medical licenses must be renewed annually based on birth month. Renewal notices are sent approximately 45 days prior to expiration. It is the physician's responsibility to keep the Board advised of his/her current address. The Board is obligated to mail the renewal information to the address on file. Failure to receive the renewal information does not relieve physicians of their renewal obligations. Physicians practicing in Minnesota without a current, valid license are practicing illegally which may result in potential liability or disciplinary action. Physicians not practicing in Minnesota who allow their licenses to lapse are cancelled after two years due to nonrenewal and must reapply and meet the requirements in place at the time in order to become licensed and resume practice in Minnesota.

If any part of this Fact Sheet conflicts with the rules or laws, the rules or laws take precedence. It is your responsibility to comply with Minnesota's laws and rules. Ignorance of the law is not a defense. Contact the Board with any questions at: 612-617-2130.



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NOTICE

In accordance with Minn. Stat. §147.091, the Board may deny an application or grant a restricted license based on the following conduct:

- a. Failure to demonstrate qualifications or satisfy licensure requirements.
- b. Obtaining a license by fraud or cheating, or attempting to subvert the licensing examination process.
- c. Conviction, during the previous five years, of a felony reasonably related to the practice of medicine.
- d. Revocation, suspension, restriction, limitation, or other disciplinary action against the person's medical license in another state or jurisdiction, failure to report to the board that charges regarding the person's license have been brought in another state or jurisdiction, or having been refused a license by any other state or jurisdiction.
- e. False or misleading advertising.
- f. Violating a rule promulgated by the board or an order of the board, a state, or federal law which relates to the practice of medicine or a state or federal narcotics or controlled substance law.
- g. Engaging in any unethical conduct; conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare or safety of a patient; or medical practice which is professionally incompetent.
- h. Failure to supervise a physician's assistant or failure to supervise a physician under any agreement with the board.
- i. Aiding or abetting an unlicensed person in practice of medicine.
- j. Adjudication as mentally incompetent, mentally ill or mentally retarded, or as a chemically dependent person, a person dangerous to the public, or a person who has psychopathic personality by a court of competent jurisdiction.
- k. Engaging in unprofessional conduct including any departure from or the failure to conform to the minimal standards of acceptable and prevailing medical practice.
- l. Inability to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, use of drugs, narcotics, chemicals or any other type of material or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills.
- m. Revealing a privileged communication from or relating to a patient except when otherwise required or permitted by law.
- n. Failure by a doctor of osteopathy to identify the school of healing in the professional use of the doctor's name.
- o. Improper management of medical records.
- p. Fee splitting.
- q. Engaging in abusive or fraudulent billing practices.
- r. Becoming addicted or habituated to a drug or intoxicant.
- s. Prescribing a drug or device for other than medically accepted therapeutic purposes.
- t. Inappropriate sexual conduct.
- u. Failure to fulfill reporting obligation.
- v. Knowingly providing false or misleading information directly related to the care of a patient unless done for accepted therapeutic purposes; e.g. administration of a placebo.
- w. Aiding suicide or aiding attempted suicide.
- x. Practicing under lapsed or non-renewed credentials.
- y. Failure to repay a state or federally secured student loan in accordance with loan provisions.
- z. Providing interstate telemedicine services other than according to section 147.032.

The Board may not grant a license to practice medicine to any person who has been convicted of a felony-level criminal sexual conduct offense. "Conviction" means a plea of guilty, a verdict of guilty by a jury, or a finding of guilty by the court and "criminal sexual conduct offense" means a violation of Minn. Stat. §§ 609.342 to 609.345 or a similar statute in another jurisdiction.

The Board will closely examine any application where applicant has been disciplined in another state. Applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.



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MEDICAL FACULTY PHYSICIAN INSTRUCTIONS

Enclosed is your application for a Minnesota medical faculty license. Please review the enclosed materials thoroughly before submitting your application. **Do NOT make commitments to start practicing medicine in Minnesota until you have been issued a license.** Any processing fees incurred are your responsibility. The board reserves the right to reject any outdated applications submitted; therefore, it is recommended that you complete the application in a timely manner. Incomplete applications will be destroyed after six months of inactivity.

ALL OF THE FOLLOWING REQUIREMENTS MUST BE MET OR THE ENTIRE APPLICATION WILL BE RETURNED.

___ **Application fees.** Fee of \$392 (\$200 processing fee and \$192 annual registration fee). *These fees are not refundable and must be in U.S. currency.* Make checks payable to the **Minnesota Board of Medical Practice.**

___ **Accounting of time.** All your time must be accounted for on the application, from high school to the date of application using month and year. During continuous years of education, periods of three months or less (summer break) need not be accounted for. List as practice references any facility where you are being paid outside the internship or residency program even if you are practicing at the same facility.

___ **Name.** The name on the application and medical diploma must be the same. If there has been a name change, submit a **notarized** copy of the documentation of name change, e.g. marriage certificate.

___ **Photograph.** A full face, recent 2"x3" photograph must be affixed as indicated on the application and **notarized** next to the picture as a true likeness. The notary seal must fall partly upon the photograph and partly upon the application.

___ **Identification.** Copy of driver's license **notarized** as a true likeness. The copy must be legible with a clear photo.

___ **International medical graduates.** Copies of the following original documents with certified translations. Documents provided by FCVS are accepted in lieu of **notarized** copies.

- a. Birth record/passport - **notarized**
- b. Medical diploma **notarized**
- c. US/Canadian postgraduate certificates

___ **Military papers.** **Notarized** copy of military discharge papers (DD Form 214), if applicable.

___ **Addendum to application.** Complete, sign, and date the Addendum to Application form.

___ **Malpractice history.** Complete, sign, and date the Malpractice History Report form. If you have had no malpractice suits, write "None", sign and date form. For each malpractice suit in which you have been named, complete the Malpractice Liability Claims Information form.

___ **Facilities list.** Please list all facilities where you have had medical privileges during the last 10 years. List any facility where you are or have been paid outside the post graduate training program. If you have had no medical privileges, write “None”, sign and date the form.

___ **Treating physician statement.** If you answered “yes” to question 4, Page 7 of the application re: certain medical conditions within the last 5 years, have your treating physician complete the form and return directly to the Board. If not applicable, write “not applicable” on the form and submit with application.

THE FOLLOWING REQUIRED DOCUMENTATION MUST BE SENT DIRECTLY TO THE MINNESOTA BOARD OF MEDICAL PRACTICE FROM THE FACILITY/PERSON COMPLETING THE FORM:

Note: Applicants may use the Federation Credentialing Verification Service (FCVS) when applying for a Minnesota medical faculty license. The FCVS verifies medical education, ECFMG certification, exam scores (USMLE, NBME, NBOME, FLEX, LMCC), and all accredited US/Canadian training. The FCVS contact telephone number is 888-275-3287 or, if you have questions regarding your application, the FCVS website is www.fsmb.org. (Please disregard these verification forms in your application materials.)

___ **Appointment to serve as a medical faculty member.** An original letter, addressed to the Board, must be sent **directly** to the Board, on letterhead and signed by the appointing authority, attesting to the requirements of Minnesota Statutes, section 147.0375, subd. 1, para. (d). *NOTE: A copy of a letter of hire is not sufficient to meet this requirement.*

___ **Medical school verification.** Submit the Medical School Verification form to each medical school attended, even if you did not graduate. Medical schools must send the completed forms **directly** to the board. Some schools will also provide a copy of your diploma upon request.

___ **Postgraduate training.** Submit the Postgraduate Training Verification form to each training program whether or not it was accredited or completed. The training programs must send the completed forms **directly** to the board.

___ **License verifications.** A verification must be received from every board issuing any type of medical license, including training license or permit, locum tenens license, and temporary permit. Make photocopies or download additional forms as needed. Verifications through VeriDoc are also accepted. Log on to www.veridoc.org and follow the onscreen instructions.

___ **Hospital privileges.** Submit the Hospital Privileges form to each hospital you listed on the Facilities List. Hospital must send the completed form **directly** to the Board.

___ **Recommendations.** Obtain recommendations from two physicians you have known for at least one year and practiced with during the last five years who can testify to your character, personal reputation, background, and professional ability. The physicians must send the completed forms **directly** to the Board.

The DataBank (NPDB/HIPDB) report.

Go to <http://www.npdb-hipdb.hrsa.gov/pract/hasAReportBeenFiledOnYou.jsp> and click on “Start a Self-Query on an Individual (Search on Myself).” Complete the required information on the Self-Query Input screens and then print a copy of the generated self-query. Sign the formatted copy (in ink) in the presence of a notary public and mail the notarized form to The Data Bank. Please request a mailed copy so that The Data Bank will mail the Self Query report directly to you. You must then mail all of the original report in the unopened envelope you received directly to this office.

Alternatively, if opened, you may submit a **notarized** copy of the **ENTIRE** packet. Call 800-767-6732 or email help@npdb-hipdb.hrsa.gov for assistance.

Minnesota Statutes no longer require all applicants to make a personal appearance before a Board representative; however, some applicants may be required to make a personal appearance as part of the application process. Applicants must submit written notification to the Board within 30 days of any name or address change.

APPLICATION FOR MEDICAL FACULTY LICENSE

MINNESOTA BOARD OF MEDICAL PRACTICE
UNIVERSITY PARK PLAZA
2829 UNIVERSITY AVENUE SE, SUITE 500
MINNEAPOLIS, MINNESOTA 55414-3246
612-617-2130 or www.bmp.state.mn.us
Hearing Impaired-Minnesota Relay Service
Metro Area 297-5353
Outside Metro Area 1-800-627-3529



APPLICATION #: _____

CHECK/RECEIPT #: _____

AMT PAID: _____

BOARD ACTION: _____

BOARD DATE: _____

LICENSE #: _____

Instructions to Applicant

1. The application will be returned if the appropriate fee is not included or the questions are not answered completely, accurately, and legibly.
2. Account for all time from the beginning of high school, whether spent in school, practice, or otherwise. Dates must include Month and Year. Attach separate sheet if necessary.
3. Failure to answer all questions completely and accurately, omission or falsification of material facts, or alteration of application may be cause for denial of your application or disciplinary action if you are subsequently licensed by the Board.
4. Incomplete applications may be destroyed after six months of inactivity.

ACCOUNT CODE	AMOUNT
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635009 lic	_____
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635010 app	_____
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Medical Professional Name If your name has changed at any time during your life and you are not using FCVS, submit a copy of the legal documentation (marriage certificate, divorce decree, etc.).

Last Name _____

First Name _____

Middle Name _____

Maiden Name _____

All Other Names Used _____

Designated Address (Public, required by Minn. Stat. 13.41, Subd. 2, will be placed on license and on our website)

Street _____

City _____ State _____ Zip Code _____ Country _____

Phone _____ Email (optional) _____

Private Address (cannot be accessed by public)

Street _____

City _____ State _____ Zip Code _____ Country _____

Phone _____ Email _____

Intended Address (if known) Effective Date _____

Street _____

City _____ State _____ Zip Code _____ Country _____

Applicant Name _____ Last 4 digits of SSN _____ Date _____

Identification Submit a notarized copy of your US/Canadian driver's license.

Date of Birth (mm/dd/yyyy) _____ Birth City _____ Birth State _____
Birth County _____ Birth Country _____ Gender _____
Driver's license: State _____ Number _____ SSN _____ NPI _____
Height (ft/in) _____ Weight (lbs) _____ Hair Color _____ Eye Color _____

Minn. Stat. § 147.091 Subd. 7(d) requires all applicants to provide their social security number on their license application for the administration of the state tax code. Your social security number is private. Your social security number is also required to facilitate reporting of the DataBank and for accurate identification under the federal and state child support enforcement law. The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard and a unique number for covered health care providers.

Medical School List all medical schools you have attended including those from which you did not graduate. If you are not using FCVS, complete the "Medical Education Verification" form and send to all medical schools you have attended. Include a copy of your diploma for the medical school to attach their seal prior to forwarding to the Minnesota Board.

1. School Name _____
Address _____
City _____ State _____ Zip Code _____ Country _____
Attended from _____ to _____ Graduation Date _____ Degree _____
(mm/dd/yyyy) (mm/dd/yyyy) (mm/dd/yyyy)

2. School Name _____
Address _____
City _____ State _____ Zip Code _____ Country _____
Attended from _____ to _____ Graduation Date _____ Degree _____
(mm/dd/yyyy) (mm/dd/yyyy) (mm/dd/yyyy)

Military Service. Submit a notarized copy of military discharge papers (DD Form 214), if applicable.

Branch of Service _____ Entry Date (mm/dd/yyyy) _____ Release Date (mm/dd/yyyy) _____
Rank at Discharge _____ Type of Discharge _____

US/Canadian Licensure Complete the attached "Licensure Verification" form and forward to the US/Canadian board issuing any type of medical license including training, locum tenens, and temporary permit, even if license is not current. Attach an additional sheet as needed. The verifying entity must forward all documentation **DIRECTLY** to this Board. Some boards charge a fee for this information.

State _____ License Number _____ Date Issued _____
State _____ License Number _____ Date Issued _____

Applicant Name _____ Last 4 digits of SSN _____ Date _____

Countries (other than U.S. and Canada) in which you have ever been licensed:

Country _____ License Number _____ Date Issued _____
Country _____ License Number _____ Date Issued _____
Country _____ License Number _____ Date Issued _____

High school or equivalent (attach a separate sheet, if necessary)

From (mo/yr): _____ High School _____
To (mo/yr): _____ City _____ State _____ Country _____

College education (attach a separate sheet, if necessary)

From (mo/yr): _____ College _____
To (mo/yr): _____ City _____ State _____ Country _____

Activities (copy and attach additional pages as needed) List below **all medical and non-medical activities** beginning with your graduation from high school to the present date including periods of unemployment and military duty and excluding post graduate training listed on page 5. For any non-working time, state on the form what your activities were (e.g. vacation, seeking employment). If you did locum tenens, list facilities where you worked.

From (mo/yr): _____ Activity _____
_____ Address _____
To (mo/yr): _____ City _____ State _____ Country _____
_____ Position _____ % Clinical _____ %Administrative _____

From (mo/yr): _____ Activity _____
_____ Address _____
To (mo/yr): _____ City _____ State _____ Country _____
_____ Position _____ % Clinical _____ %Administrative _____

From (mo/yr): _____ Activity _____
_____ Address _____
To (mo/yr): _____ City _____ State _____ Country _____
_____ Position _____ % Clinical _____ %Administrative _____

From (mo/yr): _____ Activity _____
_____ Address _____
To (mo/yr): _____ City _____ State _____ Country _____
_____ Position _____ % Clinical _____ %Administrative _____

Applicant Name _____ Last 4 digits of SSN _____ Date _____

From (mo/yr): Activity _____
Address _____
To (mo/yr): City _____ State _____ Country _____
Position _____ % Clinical _____ %Administrative _____

From (mo/yr): Activity _____
Address _____
To (mo/yr): City _____ State _____ Country _____
Position _____ % Clinical _____ %Administrative _____

From (mo/yr): Activity _____
Address _____
To (mo/yr): City _____ State _____ Country _____
Position _____ % Clinical _____ %Administrative _____

Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. If you are not using FCVS, you must complete the attached "Post graduate Training Verification" form and send to **all** postgraduate training programs you have attended. Submit a copy of your certificate of program completion. The post graduate program must forward the documentation **DIRECTLY** to this Board. Copy and attach additional pages if necessary

1. Hospital Name _____
Hospital Address _____
City _____ State _____ Zip Code _____ Country _____
PGY: (e.g., 1, 2, 3, etc.) ___ Internship ___ Residency ___ Fellowship ___ Research ___ Other
Department/Specialty _____
From _____ / _____ To _____ / _____ Successfully Completed? ___ Yes ___ No ___ In Progress
Month Year Month Year

2. Hospital Name _____
Hospital Address _____
City _____ State _____ Zip Code _____ Country _____
PGY: (e.g., 1, 2, 3, etc.) ___ Internship ___ Residency ___ Fellowship ___ Research ___ Other
Department/Specialty _____
From _____ / _____ To _____ / _____ Successfully Completed? ___ Yes ___ No ___ In Progress
Month Year Month Year

3. Hospital Name _____
Hospital Address _____
City _____ State _____ Zip Code _____ Country _____

Applicant Name _____ Last 4 digits of SSN _____ Date _____

PGY: (e.g., 1, 2, 3, etc.) ___ Internship ___ Residency ___ Fellowship ___ Research ___ Other
Department/Specialty _____
From ____/____/____ To ____/____/____ Successfully Completed? ___ Yes ___ No ___ In Progress
Month Year Month Year

4. Hospital Name _____
Hospital Address _____
City _____ State _____ Zip Code _____ Country _____
PGY: (e.g., 1, 2, 3, etc.) ___ Internship ___ Residency ___ Fellowship ___ Research ___ Other
Department/Specialty _____
From ____/____/____ To ____/____/____ Successfully Completed? ___ Yes ___ No ___ In Progress
Month Year Month Year

Attestation questions Except for questions 1-4, please answer all questions by selecting Yes or No and provide an explanation when requested. Questions 1-4 do not have “No” as an option for confidentiality reasons. If you have a condition addressed by questions 1-4 and you are NOT participating in the Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer “Yes” to the applicable question(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s). For questions 1-2, the terms “impaired” and “limited” include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders or conditions, or chemical dependency or chemical abuse. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your application is pending and public after your license is granted. Exception: “Yes” answers are confidential during any investigation and private thereafter. This information will NOT be included in the public profiling. If responses to questions change during the time your application is pending, you must make the board aware of the new information. If additional space is needed, please attach a separate sheet.

Yes 1. Is your cognitive, communicative, or physical capability to engage in the practice of medicine or surgery with reasonable skill and safety impaired or limited in any way? Please describe.

Yes No 1a. If yes, are the limitations or impairments reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe. _____

Yes No 1b. If yes, are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe. _____

Yes 2. Does your use of alcohol or chemical substance(s), including prescription medications, in any way impair or limit your ability to practice medicine with reasonable skill and safety? Please describe.

Applicant Name _____ Last 4 digits of SSN _____ Date _____

Yes 3. Are you engaged in any illegal use of controlled substances including the use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider)? Please describe.

Yes No 3a. If yes, have you taken any steps (i.e. treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe.

Yes No 3b. If yes, are you not participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe.

Yes 4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice medicine with reasonable skill and safety? If you answer this question "yes", please answer the following:

Yes No 4a. With regard to any condition referenced above, are you being treated so that such impairment is avoided?

Yes No 4b. With regard to any condition referenced above, are you in compliance with the recommended treatment?

Yes No 4c. With regard to any condition referenced above, has your treating physician advised you that you are able to practice medicine with reasonable skill and safety?

4d. Please explain _____

4e. Identify your treating physician _____

Yes No 5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? Please describe.

Yes No 6. Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars.

Yes No 7. Have you ever been denied a license, or the privilege of taking an examination before any medical examining board, or has a conditioned license been issued to you by any state medical board or licensing authority? If so, give particulars.

Yes No 8. Has your license to practice medicine in any state or country been voluntarily or involuntarily (i.e. by medical Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a Medical Board or other licensing authority? If so, give particulars.

Applicant Name _____ Last 4 digits of SSN _____ Date _____

Yes No 9. Have you ever been notified of any investigation by any state medical board, medical society, or any hospital of any complaints against you relative to the practice of medicine, or have you been reprimanded or censured by any medical society or licensing board? If so, give particulars.

Yes No 10. Have you ever been a defendant in any malpractice lawsuit, had any malpractice settlement, or have any pending? If so, use the Malpractice Liability Claims Information form to provide a detailed clinical explanation of each case, as well as documentation of outcome (insurance papers or court documents).

Yes No 11. Have your hospital privileges been restricted or revoked? If so, give particulars.

Yes No 12. Have there ever been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, submit a personal statement regarding the date of conduct, state and local jurisdiction in which the charges were filed, date of closure, what role you played, and the outcome.

Yes No 13. Have there ever been any charges filed against you for Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemical filed against you? If so, submit a detailed personal statement regarding the date of conduct, state and local jurisdiction in which the charges were filed, explaining in detail the incident and consequences including whether a CD evaluation was done (if so, submit results), and description of current use.

Yes No 14. Have you ever voluntarily or involuntarily surrendered your DEA certificate or the right to prescribe controlled substances? If so, give particulars.

Applicant Name _____ Last 4 digits of SSN _____ Date _____

Affidavit and Release

I, the undersigned, hereby certify under oath that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of Minnesota: that I am the person named in the diploma, which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, personal references, personal physicians, employers (past and present), business and professional associates (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for licensure in Minnesota.

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 of oral information or of documents, records, or other information to the Board.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice medicine in Minnesota. I understand that I am required to update my application with pertinent information to cover the time period between the date of application and date approved by the Board.

State of: _____, County of: _____

Sworn to before me this _____ day of _____, _____.

Signature of Applicant

Date of signature (must correspond to date of notarization)

Signature of Notary Public

My Commission Expires: _____

RIGHTS OF SUBJECTS OF DATA

The information on your application is requested by the Minnesota Board of Medical Practice. The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. The information is classified as private while your application is pending or if your application is denied, and as public if your license is granted. You are required to submit this information. Your application will not be processed without it and the form will be returned to you for completion. This information may be used as the basis for further investigation by the Board into your qualifications. Under some circumstances, the information could become available to other agencies or persons authorized by law to have access. Attach a separate page for detailed explanations, when appropriate. Failure to answer all questions completely and accurately, omission or falsification of material facts, alteration of application may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.

Applicant Name _____ Last 4 digits of SSN _____ Date _____



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ADDENDUM TO APPLICATION

1. BUSINESS ADDRESS

Effective August 1, 2012, Minn. Stat. §214.073 requires licensees to provide a primary business address at the time of initial application and all subsequent renewals. Your primary business address is public and you are required to submit it for application purposes. Your license will not be issued without it unless you check the box below certifying that you are not currently in the workforce related to your practice.

Facility name _____

Street Address _____

City _____ State _____ Zip _____

I certify that I am not currently in the workforce related to my practice, and I don't have a business address related to my practice.

2. MILITARY STATUS

Are you or your spouse returning from active military duty (discharged less than 6 months ago) or still in active military duty?

No Yes. If discharged, please provide discharge date: _____

3. CRIMINAL CONVICTIONS

Effective July 1, 2013, Minn. Stat. §214.072 requires the Board to collect and post on its website the name and business address of each regulated individual who has been convicted of a felony or gross misdemeanor occurring on or after July 1, 2013 in any state or jurisdiction. This information shall be posted for new licensees issued a license on or after July 1, 2013 and for current licensees upon license renewal occurring on or after July 1, 2013. This information is public and you are required to submit it for application purposes. You must notify the Board if a previously reported conviction has been expunged and provide written documentation of expungement.

If you have more than one item to report please attach additional sheets.

Conviction Date (mm/dd/yyyy): _____

Conviction Type (Check one): Felony Gross misdemeanor

Crime Description: _____

City: _____ State: _____ County: _____ Country: _____

Sentence: _____

I certify that I have had no convictions on or after July, 1, 2013

Applicant Name _____ Last 4 digits of SSN _____ Date _____



MINNESOTA BOARD OF MEDICAL PRACTICE

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MN Relay Service for Hearing Impaired (800) 627-3529

MALPRACTICE HISTORY REPORT

The Board requires information on all malpractice suits. For each malpractice suit in which you have been named, complete the Malpractice Liability Claims Information form and submit insurance papers or other formal documentation of the outcome/status.

NAME AND ADDRESS OF PROFESSIONAL LIABILITY INSURER IN OTHER STATE:

1. _____
2. _____
3. _____

NUMBER, DATE, AND DISPOSITION OF ANY MEDICAL MALPRACTICE SETTLEMENT OR AWARD RELATING TO THE QUALITY OF MEDICAL TREATMENT:*

<u>Number</u>	<u>Date</u>	<u>Disposition</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby certify that the above is a true and accurate statement.

Print Name _____

Signature _____ Date _____

*If you have had no malpractice suits, write **NONE**, sign and date this form.



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Malpractice Liability Claims Information

(copy the form to report additional claims)

Malpractice: Give a detailed clinical explanation of each case as well as documentation of outcome (insurance papers or court documents).

Name of patient involved _____

In which state did the action take place? _____ Which court? _____

Current status of this claim:

Open (pending) Closed (settled) Dismissed (no money paid out) Other _____

Amount of judgment/ settlement \$ _____ Amount paid on your behalf \$ _____

Date of event precipitating claim ____/____/____ Date of lawsuit ____/____/____ Case number _____
Month Year Month Year

Insurance carrier at time of event/ claim _____

What is/was your status? Primary defendant Co-defendant Other _____

Please provide specifics in reference to the adverse event including the allegations and your role in the event.

Name of patient involved _____

In which state did the action take place? _____ Which court? _____

Current status of this claim:

Open (pending) Closed (settled) Dismissed (no money paid out) Other _____

Amount of judgment/ settlement \$ _____ Amount paid on your behalf \$ _____

Date of event precipitating claim ____/____/____ Date of lawsuit ____/____/____ Case number _____
Month Year Month Year

Insurance carrier at time of event/ claim _____

What is/was your status? Primary defendant Co-defendant Other _____

Please provide specifics in reference to the adverse event including the allegations and your role in the event.

Applicant Name _____ Last 4 digits of SSN _____ Date _____



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FACILITIES LIST

The Board requires a list of all facilities where you have had medical privileges during the last 10 years. List any facility where you are or have been paid outside a post graduate internship, residency or fellowship training program. Submit a Hospital Privilege Form to each facility listed except those clinics which are strictly outpatient. If you have had no privileges, write **NONE** and sign and date the form.

CURRENT PRIVILEGES

<u>Facility</u>	<u>City and State</u>	<u>Type of Privilege</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST PRIVILEGES (LAST 10 YEARS)

<u>Facility</u>	<u>City and State</u>	<u>Type of Privilege</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby certify that the above is a true and accurate list of inpatient and outpatient facilities at which I have (have had) medical privileges.

Print Name _____

Signature _____ Date _____



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Treating Physician Statement

Applicant: Applicants who have or have had a medical condition during the last five years which, if untreated, would be likely to impair his/her ability to practice with reasonable skill and safety must have his/her 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.**

Applicant's Printed Name _____

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 of oral information or documents, records, or other information to the Board.

Signed _____ Date _____

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

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 _____



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CERTIFICATION OF MEDICAL EDUCATION

This form is for certification of medical education and must be completed and 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.



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VERIFICATION OF POSTGRADUATE MEDICAL TRAINING

(Copy this form for multiple programs)

This form is for verification of all US/Canadian post graduate medical training (i.e. internship, residency and fellowship) and must be completed and mailed by the facility **DIRECTLY** to the **Minnesota Board of Medical Practice**. 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 _____

Training Dates (Month,Day,Year) _____

This section is to be completed by the Program Director or Graduate Medical Education Representative

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

Received credit for post graduate training:(# Months)_____ from date:____/____/____ to date:____/____/____

The program was accredited to provide graduate, clinical, medical training during the dates above by: (Check One) ACGME___ AOA___ RCPSC___ CFPC___ None of the above___ (explain)_____

at:(Name of Hospital or Institution) _____

located at _____
(Street Address, City, State, Zip, Country)

Affiliated Medical School Name _____ Specialty _____ PGY _____

Training Program (Check One): Internship___ Resident___ Chief Resident___ Fellowship___ Research___

Did the applicant complete all required years of the post graduate training program?

___Program was completed ___ Anticipated date of completion____/____/____

___Program was not completed because _____

Was this individual issued a certificate as proof completion of training? Yes _____ No _____

Did the individual take a leave of absence or break during training? Yes* _____ No _____

Was this individual ever placed on probation or remediation?..... Yes* _____ No _____

Was this individual ever disciplined or placed under investigation? Yes* _____ No _____

Were any limitations or special requirements placed upon this individual due to academic deficiencies, incompetence, disciplinary problems or any other reason? Yes* _____ No _____

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by Program Director or Graduate Medical Education Representative:

Print Name _____

Signature _____

Date _____ Phone _____

Fax _____ Email _____



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PHYSICIAN VERIFICATION OF LICENSURE

(Copy this form for multiple licenses)

This form is for verification of all medical licenses from every U.S./Canadian board issuing any type of medical license including training license or permit, locum tenens license, and temporary permit even if the license or permit is not current. Each Board completing the form must 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 the Board. Verifications through VeriDoc are also accepted. Log on to www.veridoc.org and follow the onscreen instructions.

Print Name _____ Last 4 digits of SSN _____
Signature _____ Date _____
License Number _____ Birthdate _____

THE STATE BOARD COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician) _____
DATE OF BIRTH: (Month, Day, Year) _____
WAS ISSUED LICENSE NUMBER: _____
BY: (state) _____ **ON:** (Month, Day, Year) _____
EXPIRATION DATE: (Month, Day, Year) _____
ISSUED ON THE BASIS OF: (Exam) _____
DISCIPLINARY ACTION EVER INITIATED, PENDING, OR INVOKED*: (Yes/No) _____
MEDICAL LICENSE EVER VOLUNTARILY RELINQUISHED*: (Yes/No) _____
ANY DEROGATORY INFORMATION WHICH YOU CAN RELEASE*: (Yes/No) _____

Print Name _____
Signature _____
Title _____
Date _____
Phone _____

*If yes, please attach letter of explanation on letterhead.
**If there is no seal, attach letter of explanation on letterhead.
NOTE TO APPLICANT: Most states charge a fee for this service.



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HOSPITAL PRIVILEGES VERIFICATION

As part of the medical license application process, the Minnesota Board of Medical Practice requires that this form be completed by each hospital where the applicant has held formal privileges within the last ten years. This form must be completed by each hospital listed on the Facilities List and mailed directly by each facility 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 _____

THE HOSPITAL COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician) _____

HAD HOSPITAL PRIVILEGES AT: (Name of Hospital) _____

LOCATED AT: (Address) _____

FROM: (Month, Day, Year) _____ **TO:** (Month, Day, Year) _____

TYPE OF PRIVILEGE: _____

ANY DISCIPLINARY ACTION? Yes* _____ No _____

ANY DEROGATORY INFORMATION ON FILE? Yes* _____ No _____

Print Name _____

Signature _____

Title _____

Date _____

Phone _____

Fax _____

SEAL **

*Please attach letter of explanation.

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



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MEDICAL FACULTY PHYSICIAN RECOMMENDATION FORM (1)

This form must be completed and mailed directly to the **Minnesota Board of Medical Practice** by two licensed physicians with whom applicant has worked during the last five years, has known applicant for more than one year and who can testify to applicant's character, personal reputation, background and professional ability. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Applicant Print Name _____
Applicant Signature _____ Date _____

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Applicant) _____

1. How long have you known the applicant? _____

2. What has been the nature of your relationship with the applicant? _____

3. How would you characterize the moral and professional conduct of the applicant? _____

4. Would you recommend that the applicant be approved for licensure for the independent, unrestricted practice of medicine? _____

5. Circle the word(s) which best describes this applicant.

- | | | |
|--------------|-----------------------|---|
| A. Marginal* | Fully Meets Standards | A. Clinical skills |
| B. Yes* | No | B. Any indication of chemical dependency? |
| C. Yes* | No | C. Any indication of malprescribing? |

*Please attach letter of explanation.

Completed By:

Printed Name _____ Signed _____

Health Profession _____ License # _____ State _____

Date _____ Phone# _____ Fax _____

Email _____



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MEDICAL FACULTY PHYSICIAN RECOMMENDATION FORM (2)

This form must be completed and mailed directly to the **Minnesota Board of Medical Practice** by two licensed physicians with whom applicant has worked during the last five years, has known applicant for more than one year and who can testify to applicant's character, personal reputation, background and professional ability. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Applicant Print Name _____

Applicant Signature _____ Date _____

THE PHYSICIAN SERVING AS A REFERENCE COMPLETES THE FOLLOWING:

RECOMMENDATION FOR: (Print Name of Applicant) _____

1. How long have you known the applicant? _____

2. What has been the nature of your relationship with the applicant? _____

3. How would you characterize the moral and professional conduct of the applicant? _____

4. Would you recommend that the applicant be approved for licensure for the independent, unrestricted practice of medicine? _____

5. Circle the word(s) which best describes this applicant.

- | | | |
|--------------|-----------------------|---|
| A. Marginal* | Fully Meets Standards | A. Clinical skills |
| B. Yes* | No | B. Any indication of chemical dependency? |
| C. Yes* | No | C. Any indication of malprescribing? |

*Please attach letter of explanation.

Completed By:

Printed Name _____ Signed _____

Health Profession _____ License # _____ State _____

Date _____ Phone# _____ Fax _____

Email _____