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

Camp Doctor Registration
Application Instructions and Requirements

Please thoroughly review these materials before submitting your application. The Medical Board reserves the right to reject any outdated applications submitted; therefore, it is recommended that you complete the application in a timely manner.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.

Methods of Registration

MN Statute 147.09, sub.3 establishes registration for a licensed or registered physician who treats the physician's home state patients or other participating patients while the physicians and those patients are participating together in outdoor recreation in this state as defined by section 86A.03, subdivision 3. All applicants must submit a completed Application For Camp Doctor Registration application to the Medical Board.

Registration Requirements:

- Submit paper application by email to medical.board@state.mn.us or mail to Minnesota Board of Medical Practice.
- Verification of your current unrestricted license. The Medical Board Physician Verification of Licensure Form or a state generated license verification letter must be sent from the state directly to the Medical Board by email or mail. Verification letters of licensure can also be requested through VeriDoc Inc. to the Medical Board. Go to http://www.veridoc.org to have a verification letter sent from another participating state board to the Medical Board.
- Any other information requested by the Board.

Notes:

- A separate Camp Doctor Registration must be submitted for each individual camp period of time.
- The Medical Board will email the registration to the applicant once issued and real-time registration information can be viewed by visiting MN Medical Board Online Verification.
- You must notify the Medical Board by email at medical.board@state.mn.us if the dates of events changes or event is cancelled before the start date shown on the registration.
- You are required to submit notification to the Board within 30 days of any name change by submitting the Request For Name Change Form and address changes in your online services account at MN Medical Board Online Services.
- The law takes precedence over any conflicts between these instructions and the law.

APPLICATION FOR CAMP DOCTOR REGISTRATION

MINNESOTA BOARD OF MEDICAL PRACTICE
335 RANDOLPH AVENUE, SUITE 140
ST. PAUL, MINNESOTA 55102
612-617-2130 or mn.gov/boards/medical-practice
Hearing Impaired-Minnesota Relay Service
Metro Area 651-297-5353
Outside Metro Area 1-800-627-3529

INSTRUCTIONS TO APPLICANT

MN Statute 147.09, sub.3 A licensed or registered physician who treats the physician's home state patients or other participating patients while the physicians and those patients are participating together in outdoor recreation in this state as defined by section 86A.03, subdivision 3. A physician shall first register with the board on a form developed by the board for that purpose. The board shall not be required to promulgate the contents of that form by rule. No fee shall be charged for this registration.

YOUR CURRENT FULL LEGAL NAME AND ADDRESS: MN Statute 13.41, subd. 2 requires designated contact information to be PUBLIC and it will be placed on the registration and the Medical Board's website. You may change this information in your online services account after your residency permit is issued.

LAST	FIRST	MIDDLE ☐ NO MIDDLE NAME
STREET ADDRESS:		

CITY:	STATE/PROVINCE:	ZIP CODE:	COUNTRY:	EMAIL:
PRIMARY PHONE:	OTHER PHONE	GENDER:	OTHER NAMES:	

DATE OF BIRTH: (MM/DD/YYYY) / /	CITY OF BIRTH:	COUNTY OF BIRTH:	STATE/PROVINCE OF BIRTH:	COUNTRY OF BIRTH:

SOCIAL SECURITY NUMBER:

☐ I do not have a US Social Security number currently but will notify the Board when I obtain a US Social Security Number.

DRIVERS LICENSE: STATE: LICENSE NUMBER: ☐ I do not have a driver's license

MEDICAL EDUCATION

NAME OF SCHOOL:	CITY:	STATE OR PROVINCE:	COUNTRY:	DATE COMPLETED: (MM/DD/YYYY) / /

MINNESOTA CAMP REGISTRATION INFORMATION

NAME OF CAMP	CITY OF CAMP	START DATE OF CAMP (MM/DD/YYYY) / /	END DATE OF CAMP (MM/DD/YYYY) / /

I, _____ swear that I am the person described and identified. I have carefully read the information 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 may constitute cause for denial, suspension, or revocation of my registration or of any later license to practice medicine in Minnesota. I have read MN Statute 147.09, sub.3. and will comply with the provision within.

Signature of Applicant: _____ Date: _____

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CAMP DOCTOR REGISTRATION ADDENDUM TO APPLICATION

1. BUSINESS ADDRESS

Effective August 1, 2012, Minn. Stat. §214.073 requires licensees to provide their 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 Adress_____

City _____ State_____ Zip_____

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

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2. CRIMINAL CONVICTIONS

Effective July 1, 2013, Minn. Stat. §214.072 requires the Board to collect and post on its website the names and business address of each regulated individual who has be conviction 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_____

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PHYSICIAN VERIFICATION OF LICENSURE

(for Camp Doctor Registration Applicants)

This form is for verification of your medical license where you are currently practicing medicine. The Board completing this form must email or mail directly to the **Minnesota Board of Medical Practice**. Any fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Medical 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 EVERY INITIATED, PENDING, OR INVOKED*: (Yes/No)_____

EVER VOLUNTARILY RELINQUISHED MEDICAL LICENSE*: (Yes/No)_____

ANY DEROGATORY INFORMATION WHICH YOU CAN RELEASE*: (Yes/No)_____

**State Stamp
or Seal

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.