
LIMITED LICENSE ADMINISTRATOR LETTER OF RECOMMENDATION

This form must be completed, mailed or emailed directly to the Minnesota Board of Medical Practice by an administrator of the hospital or clinical setting in which you have previously worked, that has known you and can testify to your 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 ADMINISTRATOR 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. Do you attest to the applicant's good medical standing? Check one: ☐ Yes or ☐ No

Completed By:

Administrator Name _____ Signature _____

Health Facility _____ US State or Country _____

Date _____ Email _____