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

LIMITED LICENSE APPLICATION INSTRUCTIONS

(Pursuant to Minnesota Statutes 147.037 — Internationally Trained Physician Limited License Pathway)

This application is intended for individuals seeking licensure through the Internationally Trained Physician (ITP) Limited License Pathway. Please review all application materials thoroughly before submission.

Applicants are responsible for all processing fees. The Board reserves the right to reject outdated application forms; therefore, timely submission is strongly encouraged. Incomplete applications may be destroyed after six months of inactivity.

To prevent processing delays, ensure your application is complete, current, and accompanied by all required documentation.

ALL OF THE FOLLOWING REQUIREMENTS MUST BE MET:

— **Application Fee:** Fee of $616.00. *These fees are not refundable and must be in U.S. currency.* Make check or money order payable to the ***Minnesota Board of Medical Practice.***

— **Criminal Background Check (CBC) Results:** The CBC Program will email the required forms and instructions directly to the applicant, along with their contact information, should you have further questions.

— **Name:** The name on the application and medical school diploma must be the same. If there has been a name change, submit a copy of the legal documentation, such as a marriage certificate. Applicants must submit written notification to the Board within 30 days of a name or address change.

— **Affidavit and Release Form:** A full face, recent photograph approximately 2x3 inches must be affixed as indicated and **notarized** next to the picture as a true likeness. The notary seal must be placed so that it overlaps both the photograph and the form. ***The applicant's signature is required directly beneath the photograph***.

— **Identification:** A copy of a current driver's license or other government issued photo id.

— **Medical School Diploma:** 8 ½" x 11" copy of medical school diploma (and translation if necessary). Documents provided by FCVS are accepted.

— **Military Documents:** Copy of discharge papers (DD Form 214); copy of ID or enlistment contract for current active duty military. (Active Military does not include Army National Guard or Air National Guard)

— **Addendum to Application Form:** Complete, sign, and date the Addendum to Application form

— **Malpractice History Report Form:** This form is required for all applicants. If you have had no malpractice suits, write "**NONE"** in the space provided, then print your name, sign, and date the form. ***"Not Applicable" or "N/A" is not an accepted response.***

— **Malpractice Liability Claims Information Form**: This form is required if you answered "Yes" to application question nine.

— **Applicant Work History Attestation**: List all facilities where you have had medical privileges during the past ten (10) years. Include any facility where you have received payment outside the postgraduate training program. If you have had no medical privileges, write **"None,"** sign, and date the form.

— **Employer Attestation**: Your employer must complete and submit this form directly to the Board.

— **Attestation of Collaborative Agreement Form:** Applicants and their collaborating physicians must complete and submit a collaborative agreement form in accordance with Minnesota Statutes section 147.037, subd. 1b(h).

— **Physician Letter of Recommendation Form**: This form must be completed and submitted directly to the Board by the physician with whom the applicant previously worked.

— **Administrator Letter of Recommendation Form**: This form must be completed and submitted directly to the Board by the administrator of a hospital or clinical setting in which the applicant previously worked.

— **Verification of Federal Immigration Status Allowing Practice**: Documentation of acceptable federal immigration status as set forth in INS Form I-9, page 2.

THE FOLLOWING REQUIREMENTS MUST BE SENT DIRECTLY TO THE MINNESOTA BOARD FROM THE FACILITY/PERSON COMPLETING THE FORM:

Note: Applicants may use the Federation Credentialing Verification Service (FCVS) when applying for a Minnesota medical license. The FCVS verifies exam scores, ECFMG certification, medical education, and the NPDB report. The FCVS contact telephone number is 888-275-3287, or if you have questions regarding your application, their website is www.fsmb.org. Please disregard the medical school verification form in your application materials if using FCVS.

— **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.

— **License Verifications:** A verification of all medical licenses from every U.S./Canadian board issuing any type of license, including training, locum tenens, and temporary permit, even if the license is not current, is required. Each Board must email, mail, or fax directly to the **Minnesota Board of Medical Practice**. Any fees are the applicant's responsibility. State Medical Board verifications and verifications through VeriDoc are also accepted. Log on to www.veridoc.org and follow the onscreen instructions. Verifications are not included in your FCVS packet.

— **The DataBank (NPDB) Report:** Go to the National Practitioner Data Bank (NPDB) website and complete a Self-Query. The NPDB provides digitally certified Self-Query results in a PDF file format, which the Board accepts from the applicant in lieu of a paper copy.

— **Educational Commission for Foreign Medical Graduates (ECFMG) verification (International Medical Graduates only):** Log on to www.ecfmg.org/cvs/index.html for the request form or to submit the request online. Confirmations are sent directly to the board.

— **Examination Scores:** Follow the instructions below to request direct verification for the type of exam passed.

1. **National Board of Osteopathic Medical Examiners (NBOME) – Comprehensive Osteopathic Medical Licensing Examination (COMLEX).**
    - Visit https://www.nbome.org/assessments/comlex-usa/bulletin/transcripts
    - For assistance, call 773-714-0622 or email transcript@nbome.org.

2. **United States Medical Licensing Examination (USMLE)**
    - To request a transcript, you will need to visit the Federation website, www.fsmb.org, click "FOR PHYSICIANS" at the top left, and then click "EXAM TRANSCRIPT".
    - If you have forgotten your login information, use the "Sign Up Now" to create a new account. All accounts link back to your record.
    - When sending your transcript to the Minnesota Medical Board, select the board from the drop-down menu under **"Send to Medical Authority."** Do not manually enter board information.
    - Transcripts will only be sent to the recipients listed on the request and are available to the Medical Authority via the Federation of State Medical Boards website. Do not upload your scores to the Medical Board Portal.
    - For assistance, call 817-868-4041 or email usmle@fsmb.org.

APPLICATION FOR LIMITED LICENSE

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

AMT PAID:_____

DEPOSIT #_____

Instructions to Applicant

1. The application will be returned if the fee is not included, or the questions are not answered completely, accurately, and legibly.
2. Failure to answer all questions completely and accurately, omission or falsification of material facts, or alteration of the application may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.
3. Incomplete applications may be destroyed after six months of inactivity.

Medical Professional Name. If your name has changed at any time during your life, or if the name on your application is different than the name on your graduate diploma or professional certification, please 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 the public)

Street_____

City_____ State_____ Zip Code_____Country_____

Phone_____ Email (REQUIRED)_____

Identification. Copy of driver's license or other government issued photo ID.

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.

1. School Name_____

Address_____

City_____ State_____ Zip Code_____ Country_____

Attended from_____ (mm/dd/yyyy) to_____ (mm/dd/yyyy) Graduation Date_____ (mm/dd/yyyy) Degree_____

2. School Name_____

Address_____

City_____ State_____ Zip Code_____ Country_____

Attended from_____ (mm/dd/yyyy) to_____ (mm/dd/yyyy) Graduation Date_____ (mm/dd/yyyy) Degree_____

ECFMG Certification. If ECFMG is applicable and you are not using FCVS, log on to www.ecfmg.org/cvs/index.html for the request form or to submit the request online. Confirmations are sent directly to the Minnesota Board.

Certificate Number_____ Issue Date_____ Valid Through Date_____

Exam History. Please check all that apply:

☐ USMLE ☐ COMLEX

To request direct verification, see instructions on page two.

US/Canadian Licensure. Complete the attached "Licensure Verification" form and forward to 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 necessary. 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_____

State_____ License Number_____ Date Issued_____

State_____ License Number_____ Date Issued_____

State_____ License Number_____ Date Issued_____

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_____

Attestation questions: Please answer all questions by selecting Yes or No and provide an explanation when requested. 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 necessary, please attach a separate sheet.

Yes ☐ **No** ☐ 1. Do you currently have any condition that is not being appropriately treated which is likely to impair or adversely affect your ability to practice medicine with reasonable skill and safety in a competent, ethical, and professional manner? If yes, please describe.

_____

_____

Yes ☐ **No** ☐ 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? If yes, please describe.

_____

_____

Yes ☐ **No** ☐ 3. Are you engaged in 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)? If yes, please describe.

_____

_____

Yes ☐ **No** ☐ 4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? If yes, please describe.

_____

_____

Yes ☐ **No** ☐ 5. Have you ever been the subject of an investigation by any federal, state, or local agency having jurisdiction over controlled substances? If yes, please describe.

_____

_____

Yes ☐ **No** ☐ 6. 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 yes, please describe.

_____

_____

Yes ☐ **No** ☐ 7. 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 yes, please describe.

_____

_____

Yes ☐ **No** ☐ 8. Have you ever been notified of an investigation by a state medical board, medical society, or 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 yes, please describe.

_____

_____

Yes No 9. In the five-year period of active practice preceding the date of filing your application, have you been a defendant in any malpractice lawsuits, had any malpractice settlements, or have any pending? If yes, give a detailed clinical explanation of each case on the Malpractice Liability Claims Information form and provide documentation of the outcome (insurance papers or court documents).

Yes No 10. Have your hospital privileges ever been restricted or revoked? If yes, please describe.

_____

_____

Yes No 11. Have there ever been any criminal charges filed against you, whether the charges were misdemeanor, gross misdemeanor, or felony? This includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If yes, 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. If the charge involved the use of alcohol or other chemicals, include in your personal statement whether a chemical dependency evaluation was done (and if so, submit results) and a description of your current drinking or other substance use habits.

Yes No 12. Have you ever voluntarily or involuntarily surrendered your Drug Enforcement Agency (DEA) certificate or the right to prescribe controlled substances? If yes, please describe.

_____

_____

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Affidavit and Release

State of: _____ County of: _____

I, _____ , swear that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of Minnesota and that I am of good moral character: 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, my 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 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 limited 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 date of application and date approved by the Board.

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

_____
Signature of Applicant

Signature of Notary Public _____

My Commission Expires: _____

CERTIFICATION OF IDENTIFICATION
Certification of Notary Public is required.

I certify that on the date set forth below, the individual named above did appear Personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. Sworn to before me by the applicant on

this _____ day of _____ , _____.

Signature of Notary Public _____

Expiration Date _____ / _____ / _____

Paste a recent photo, front-view passport-type photo in this square

NOTARY SEAL
NATARY

_____
Signature of Applicant

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 fact, alteration of application may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.

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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 Address_____

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.

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 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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MALPRACTICE HISTORY REPORT

The Board requires information on all malpractice suits in the five-year period of active practice preceding the date of filing your application. For each such 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.

If you have had no malpractice suits, write **NONE**: _____
(N/A or Not Applicable ***is not an accepted response***)

Number	Date	Disposition

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

Print Name_____

Signature_____ Date_____

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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 of settlement $_____ Amount paid on your behalf $_____

Date of event precipitating claim_____/_____ Date of lawsuit_____/_____ Case number_____
Month Year Month Year

Insurance carrier at time_____

What is/was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other_____

Please provide specifics in reference to the adverse even 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 of settlement $_____ Amount paid on your behalf $_____

Date of event precipitating claim_____/_____ Date of lawsuit_____/_____ Case number_____
Month Year Month Year

Insurance carrier at time_____

What is/was your status? ☐ Primary defendant ☐ Co-defendant ☐ Other_____

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

_____

_____

_____

_____

_____

Applicant Name_____ Last 4 digits of SSN_____ Date_____

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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.

8/23

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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 license including training, locum tenens, and temporary permit even if license is not current. Each Board completing the form must email, mail or fax 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.

State Medical Board verifications and verifications through VeriDoc are also accepted in lieu of this form. 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)_____

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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LIMITED LICENSE APPLICANT WORK HISTORY ATTESTATION

To be eligible for the limited license, Minnesota law requires physicians to have engaged in the practice of medicine, pursuant to a license or other authorization to practice, for at least 60 months within the previous 12 years outside of the United States.

Minnesota law defines the practice of medicine for purposes of the limited license application as including the following:

(1) offers or undertakes to prescribe, give, or administer any drug or medicine for the use of another;
(2) offers or undertakes to prevent or to diagnose, correct, or treat in any manner or by any means, methods, devices, or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity or defect of any person; or
(3) offers or undertakes to perform any surgical operation including any invasive or noninvasive procedures involving the use of a laser or laser assisted device, upon any person.

License Type	Issuing Country	Facility	City	Country	Start Date	End Date	Total Months

I hereby attest that the above is true and accurate.

Print Name: _____

Signature: _____

Date: _____

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LIMITED LICENSE EMPLOYER ATTESTATION

This form must be completed and mailed or emailed directly to the **Minnesota Board of Medical Practice** by the employer. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Applicant Print Name _____

Applicant Signature _____ Date_____

THE EMPLOYER COMPLETES THE FOLLOWING:

Minnesota Statutes section 147.037, subdivision 1b requires that the limited license application meet the following requirements:

1. The applicant for a limited license will provide services in a designated rural area or underserved urban community as defined in Minnesota Statutes section 144.1501.

   Designated rural area means a home rule charter city or township that is outside the seven-county metropolitan area, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

Rural Area	Clinic Name	Clinic Address	County

Underserved urban community means a health professional shortage area ("HPSA"), medically underserved area ("MAP"), or medically underserved population ("MUP") as designed by the United States Department of Health and Human Services.

Underserved Community	Clinic Name	Clinic Address	County	HPSA/MUA/MUP Number

☐ By checking this box, I attest that the above applicant, employee of our clinic, will practice in the designated rural area or underserved urban community, as specified above.

11/2025

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2. The applicant for a limited license has an offer to practice within the context of a collaborative agreement within a hospital or clinical setting where the limited license holder and physicians work together to provide patient care.

   ☐ By checking this box, I attest that the above applicant has a collaborative agreement with a Minnesota licensed physician(s) within our hospital or clinical setting. The collaborating physician(s) is:

Physician Last Name	First Name	MN License Number	License Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____

3. An employer of a limited license holder must pay the limited license holder at least an amount equivalent to a medical resident in a comparable field and must carry medical malpractice insurance covering a limited license holder for the duration of the employment.

   ☐ By checking this box, I attest that our clinic will pay the limited license holder at least an amount equivalent to a medical resident in a comparable field and will carry medical malpractice insurance covering the limited license holder for the duration of employment.

4. Applicants for physician limited licenses must possess federal immigration status that allows the applicant to practice as a physician in the United States.

   ☐ By checking this box, I attest that, to a reasonable degree and in accordance with federal immigration law, the employer has verified that applicant possesses a federal immigration status that allows the applicant to practice as a physician in the United States.

Print Name: _____ Title: _____

Signed: _____ Date: _____

Email: _____ Phone: _____

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LIMITED LICENSE COLLABORATIVE PRACTICE ATTESTATION

Limited License Holder: _____ Effective Date of Agreement: _____

Collaborating Physician: _____ Duration of Agreement: _____

In accordance with **Minnesota Statutes, section 147.037, subd. 1b(a)(2) and (h),**

The limited license holder and one of the collaborating physicians must have experience in providing care to patients with the same or similar medical conditions. Under the collaborative agreement, the following terms must be met:

- The limited license holder must shadow the collaborating physician for four weeks.
- After the four weeks of shadowing the collaborative physician, the limited license holder must staff all patient encounters with the collaborating physician for an additional four weeks.
- After these first eight weeks of shadowing and staffing all patient encounters, the collaborating physician has discretion to allow the limited license holder to see patients independently and may, at the discretion of the collaborating physician, require the limited license holder to present patients.
- The limited license holder must continue to be supervised by the collaborating physician for a minimum of two hours per week for the duration of the time the limited license is active.
- The limited license holder must have one-on-one practice reviews with each collaborating physician, provided in person or through eye-to-eye electronic media while maintaining visual contact, for at least two hours per week.
- A limited license holder may practice medicine without a collaborating physician physically present, but the limited license holder and collaborating physicians must be able to easily contact each other by radio, telephone, or other telecommunication device while the limited license holder practices medicine.

APPLICANT/LICENSEE INFORMATION			
LAST NAME	FIRST NAME	MIDDLE NAME	
STREET ADDRESS			
CITY	STATE/PROVINCE	ZIP/POSTAL CODE	COUNTRY
BIRTH DATE (mm/dd/yyyy)			

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

COLLABORATING PHYSICIAN INFORMATION		
NAME	PHONE NUMBER	EMAIL
PRACTICE SPECIALTY	PRACTICE SITE NAME/LOCATION	LICENSE NUMBER

The undersigned attest that the physician limited license holder is practicing under a collaborative practice agreement that complies with Minnesota Statutes, section 147.037, subd. 1b(a)(2) and (h).

Limited License Holder: _____ _____ _____
Print Name | Signature | Date (mm/dd/yyyy)

Collaborating Physician: _____ _____ _____
Print Name | Signature | Date (mm/dd/yyyy)

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LIMITED LICENSE PHYSICIAN LETTER OF RECOMMENDATION

This form must be completed, mailed or emailed directly to the Minnesota Board of Medical Practice by a physician with whom the applicant has worked with and who 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 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. Do you attest to the applicant's good medical standing? Check one: ☐ Yes or ☐ No

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Completed By:

Physician Name _____ Signed _____

Health Facility _____ License # _____ US State or Country_____

Date _____ Email _____

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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

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Completed By:

Administrator Name _____ Signature _____

Health Facility _____ US State or Country _____

Date _____ Email _____