MINNESOTA
BOARD OF MEDICAL PRACTICE

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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 _____

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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 _____