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

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.

Domestic Graduate Requirements

1. Graduate of an accredited medical or osteopathic school located in the United States, its territories, or Canada.
2. Successfully complete one year of U.S./Canadian graduate, clinical medical training in a program accredited by the Accreditation Council of Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) or the Royal College of Physicians & Surgeons of Canada, or the College of Family Physicians of Canada (CFPC) or other graduate training approved, in advance, by the board as meeting standards similar to those of a national accrediting organization.
3. Successfully complete the USMLE, COMLEX, National Board, LMCC, FLEX or state exam. Applicants licensed in another state must pass the SPEX exam within three attempts if it has been more than 10 years since taking the initial licensing exam unless currently certified by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association Bureau of Professional Education, of the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada.

International Graduate Requirements

1. Graduate of a medical school listed in the World Directory of Medical Schools.
2. Successfully complete one year of graduate, clinical medical training in a program accredited by a national accrediting organization approved by the board 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. See Minn. Stat. §147.037 Subd. 1(d) for details.
3. ECFMG certificate.
4. Successfully complete the USMLE, FLEX, LMCC or state exam. Applicants must pass the SPEX exam within three attempts if it has been more than 10 years since taking the initial licensing exam unless currently certified by a specialty board of the American Board of Medical Specialties, of the American Osteopathic Association Bureau of Professional Education, of the Royal College of Physicians and Surgeons of Canada, or of the College of Family Physicians of Canada.

USMLE REQUIREMENTS

Applicants must have passed steps 1, 2 and 3 within three attempts. Four attempts are allowed if currently licensed in another state and currently certified by a specialty board of ABMS, AOABPE, RCPSC, or CFPC. USMLE Step 3 must be passed within 5 years of Step 2 or before the end of residency training. Applicants must pass each step with passing scores as recommended by the USMLE program. Combinations of FLEX, National Board, and USMLE (as outlined in the USMLE bulletin) may be accepted by the Board as comparable to existing exam sequences, but all exams must be passed within three attempts and completed prior to the year 2000.

COMLEX EXAM-USA

Applicants must have passed levels one, two and three with passing scores within three attempts.

FLEX EXAM REQUIREMENTS

Eligibility requirements for medical licensure in Minnesota based on the FLEX exam are as follows:

1. Applicants who took and passed FLEX prior to 1985 must have passed in one sitting within five attempts.

2. Applicants who took and passed FLEX between 1985 and 1990 may pass in two sittings providing it is within five attempts.
3. Applicants who have made up to five attempts to pass FLEX (some attempts before 1985 and some between 1985 and 1990, inclusive) may pass in two sittings between 1985 and 1990.
4. Applicants taking FLEX after 1990 may pass in two sittings within three attempts.

The latest score is the "official score". Passing score is a weighted average of 75 prior to 1985; thereafter, the passing score is 75 on each component.

PERMITS

A physician must have a residency permit to participate in a residency program unless licensed by the Board. The residency permit is program specific; therefore, a separate residency permit is required for each residency program until a physician is licensed.

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 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 their 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 obligation. 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 license 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 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. Ignorance of the law is not a defense. Call Board offices with any questions.

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NOTICE

In accordance with Minnesota Statute 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 privileges 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.
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 federal 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 section 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.

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PHYSICIAN INSTRUCTIONS

Enclosed is your application for a Minnesota medical 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 use 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 $425.25 ($33.25 criminal background check, $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, e.g. marriage certificate.

___ **Photograph.** A full face, recent 2x3" 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.

___ **US/Canadian graduates only.** 8 ½" x 11" copy of medical diploma and 1st year post graduate training certificate, if issued.

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

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

___ **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 getting (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 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 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, their website is www.fsmb.org. Please disregard these verification forms in your application materials.

___ **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, training permit, locum tenens, or temporary permit. Make photocopies or download forms as necessary. Verifications through VeriDoc are also accepted. Log on to www.veridoc.org and follow the onscreen instructions.

___ **Specialty board certification.** If it has been 10 years since you passed the licensing exam, you must be currently specialty board certified by ABMS, AOA/BOS, RCPSC or CFPC. Submit the Verification of Specialty Board Certification to the appropriate specialty board. The verification must come **directly** from the specialty 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) 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 generate a **Response to Self Query** online. A PDF will be sent to you by NPDB for your records and a hard copy envelope will follow in the mail.

Alternatively, 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, requesting a mailed copy so that The Data Bank will mail the Self Query report directly to you.

The **Response to Self Query (Response)** must be forwarded directly to this office in one of the following ways:

1. Submit the unopened hard copy **Response** envelope; or
2. If opened, submit a notarized copy of the **Response**.

Call 800-767-6732 or email help@npdb-hipdb.hrsa.gov for assistance.

___ **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.** See following instructions.

FOLLOW THESE INSTRUCTIONS FOR THE TYPE OF EXAMINATION PASSED (THE MINNESOTA BOARD MUST RECEIVE THE SCORES DIRECTLY FROM THE NATIONAL BOARDS, FEDERATION, STATE BOARD OR MEDICAL COUNCIL OF CANADA OR FCVS):

1. **National Board of Medical Examiners (NBME).** Go to https://apps.nbme.org/ciw2/prod/jsp/login.jsp to request documents. For questions or assistance, call 215-590-9500 or email scores@nbme.org.

2. **National Board of Osteopathic Medical Examiners (NBOME/COMLEX-USA).** Go to http://www.nbome.org/transcript-request.asp?m-can. For questions or assistance, call 773-714-0622 or email transcript@nbome.org.

3. **United States Medical Licensing Examination (USMLE) or Federation Licensing Examination (FLEX).** Go to http://www.fsmb.org/transcripts.html. The Examination and Board Action History Report (EBAHR) is to be downloaded as well. Physicians who have not taken USMLE Step 3 should wait until Step 3 has been passed to ensure the score report includes Step 3. For questions or assistance, call 817-868-4041 or email usmle@fsmb.org.

4. **Exam Combinations (FLEX, NBME, USMLE).** Contact the National Board and/or the Federation for the release of your scores. For those who have taken any component of the NBME in conjunction with USMLE or FLEX, you must request the transcripts from the NBME.

5. **State Examination.** Contact the State Board where you took your examination and have them send your scores directly to us. There may be a fee required. A directory of state boards is located at http://www.fsmb.org/directory_smb.html.

6. **Medical Council of Canada (LMCC).** Go to www.mcc.ca, click on “Documents” and “Certified Statement of Registration” and follow the instructions. Hard copy score requests are required.

7. **SPEX Examination.** You are required to pass the SPEX examination within 3 attempts if you have not passed any of the licensing examinations listed above during the last 10 years and you are not currently certified by the American Board of Medical Specialists, American Osteopathic Association Bureau of Professional Education, Royal College of Physicians and Surgeons of Canada or College of Family Physicians of Canada. The examination is a computer-based exam administered by the Federation of State Medical Boards through Prometric Centers.

A. If you have taken SPEX in another state, download the Examination and Board Action History Report (EBAHR) from the Federation of State Medical Board's website at http://www.fsmb.org/transcripts.html. There is a processing fee involved.

B. If applying to take the SPEX exam, see information given at http://www.fsmb.org/plas_spex.html. For questions or assistance, call 817-868-4041 or emailusmle@fsmb.org.

USMLE EXAMINATION ADMINISTRATION

Applicants are eligible to take the United States Medical Licensing Exam (USMLE) Step 3 providing the following requirements are met by the Step 3 examination date: a) MD (or equivalent) or DO degree has been conferred; b) notice of successful completion of USMLE Step 1 and Step 2 within three attempts has been received; c) be currently enrolled in or completed a post graduate training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), College of Family Physicians of Canada (CFPC), or the Royal College of Physicians and Surgeons of Canada (RCPSC). The USMLE Step 3 must be passed within five years of Step 2 or before the end of residency training. The Minnesota Board of Medical Practice has contracted with the Federation of State Medical Boards to provide application processing and test administration services. The Federation has established an Examination/Registration Hotline (817)735-0722 or apply on line/download forms at www.fsmb.org. Eligibility to sit for USMLE Step 3 does not signify eligibility for a license to practice medicine and surgery in Minnesota. The licensure application process is separate from the exam application process.

Minnesota statutes no longer require all applicants to make a personal appearance before a Board representative; however, some 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 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

APPLICATION #: ___________
CHECK/RECEIPT #:_________
AMT PAID:_______________
LICENSE #:_______________

ACCOUNT CODE	AMOUNT
635009 lic	__________
635010 app	________
635064 cbc	________

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. 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, 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.

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 (REQUIRED)________________________________

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)

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__________________

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

Branch of Service____________________ Entry Date (mm/dd/yyy)____________Release Date (mm/dd/yyyy)___________

Rank at Discharge______________________________ Type of Discharge_______________________________________

Exam History. Contact the appropriate examination entity (see instructions) and arrange to have a certified transcript of your scores sent **DIRECTLY** to this Board. See Fact Sheet for exam requirements. Please check all that apply:

___ FLEX ___ LMCC ___National Board (NBME) ___USMLE ___NBOME/COMLEX

___ State Board Exam (prior to 1973) Which State?____________ Date(s) passed?_____________

Applicant Name____________________________________ Last 4 digits of SSN _________ Date______________

Proposed practice plans in Minnesota (if any):____

Current* specialty board certification (check one):

____American Board of Medical Specialties
____Royal College of Physicians and Surgeons of Canada
____College of Family Physicians of Canada
____American Osteopathic Association Bureau of Professional Education
____None of the above

Specialty____________________
Issue Date___________________
Expiration Date________________

*If it has been more than 10 years since your initial licensing exam, the SPEX exam is required unless currently specialty board certified.

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______________
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________________

High school (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__________________

Applicant Name____________________________________ Last 4 digits of SSN ________ Date_____________

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__________

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____________ 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______________

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_________________

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

Applicant Name___________________________________ Last 4 digits of SSN ________ Date______________

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 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 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 necessary, 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.

____

____

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.____

____

Applicant Name________________________________ Last 4 digits of SSN ________ Date_____________

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? I 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.

____

____

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 lawsuits, had any malpractice settlement, or have any pending? If so, give a detailed clinical explanation of each case on the Malpractice Liability Claims Information form 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.

____

____

Applicant Name_________________________________ Last 4 digits of SSN ________ Date_____________

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 of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemicals 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 drinking habits.

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

____

____

Certificate of Ethical and Moral Character

This certificate must be signed by **two** licensed physicians who are personally acquainted with the applicant.

1.

I certify that the photograph attached is a recent one and likeness of Dr. ___________________________________

And that s/he is a person of good ethical and moral character.

______________________	______________	______________	______________
SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE

____

PRINT OR TYPE FULL NAME

CERTIFICATION OF IDENTIFICATION
Certification of Notary Public is required.

State:_____________________ County:_______________________

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 ______________ , __________.

Notary Public Signature ________________________________

Expiration Date _____ / _____ / _____
Month Day Year

Paste a recent photo, front-view passport-type (2" square) photo in this square

SEAL
The impression of the seal must be partly upon the photo

____
Applicant's Signature

2.

I certify that the photograph attached is a recent one and likeness of Dr. ___________________________________

And that s/he is a person of good ethical and moral character.

______________________	______________	______________	______________
SIGNATURE	DATE	LICENSE NUMBER	STATE OF ISSUE

____

PRINT OR TYPE FULL NAME

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, 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 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.

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 fact, 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 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. 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.

If you have had no malpractice suits, write **NONE**, in the space below, print your name, sign and date this form.

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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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 getting (have been) paid outside of a postgraduate training program. If you have had no privileges, write **NONE** and sign and date the form.

CURRENT PRIVILEGES

Facility	City and State	Type of Privilege

PAST PRIVILEGES (LAST 10 YEARS)

Facility	City and State	Type of Privilege

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 a medical condition during the last five years which, if untreated, would be likely to impair their ability to practice with reasonable skill and safety must have their 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____

Applicant's 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 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.

Date first saw patient: ____________________ **Date last saw patient:** _______________________

Nature of medical condition including diagnosis and significant symptoms:

____

____

____

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 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_________________________

*Attach letter of explanation

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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 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 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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VERIFICATION OF SPECIALTY BOARD CERTIFICATION

This form is for verification of specialty board certification for applicants who have not taken a licensing exam for 10 years. Applicants are required to pass the SPEX exam if it has been more than 10 years since taking the National Board, FLEX, LMCC, or state exam unless the applicant is currently certified by a specialty board of the American Board of Medical Specialties, the American Osteopathic Association Bureau of Professional Education, the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada. The form must be mailed directly by the specialty board (e.g. American Board of Internal Medicine, **not** American Board of Medical Specialties) 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.

Print Name ______________________________ Birthdate_____________ Last 4 digits of SSN_______

Signature____ Date________________________

THE SPECIALTY BOARD COMPLETES THE FOLLOWING:

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

WAS ISSUED A CERTIFICATE ON: (Month, Day, Year)____

BY: (Name of Specialty Board)____

A SPECIALTY BOARD OF (CHECK ONE)**:**

_____The American Board of Medical Specialties
_____The American Osteopathic Association/Bureau of Osteopathic Specialists
_____The Royal College of Physicians and Surgeons of Canada
_____The College of Family Physicians of Canada

EXPIRATION DATE IS: (Month, Day, Year)____

SEAL*

Print Name___________________________
Signature____________________________
Title________________________________
Date________________________________
Phone_______________________________

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

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PHYSICIAN RECOMMENDATION FORM (1)

This form must be completed and mailed directly to the **Minnesota Board of Medical Practice** by two US or Canadian 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. This form does not have to be filled out by the same physicians you have listed on page 9 of the application. 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. Clinical skills	Marginal*	Fully Meets Standards
B. Any indication of chemical dependency?	Yes*	No
C. Any indication of malprescribing?	Yes*	No

*Please attach letter of explanation.

Completed By:

Printed Name_______________________________ Signed_______________________________

Health Profession_______________________ License #__________ State__________

Date________________ Phone#____________________ Fax________________

Email_______________________________________

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PHYSICIAN RECOMMENDATION FORM (2)

This form must be completed and mailed directly to the **Minnesota Board of Medical Practice** by two US or Canadian 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. This form does not have to be filled out by the same physicians you have listed on page 9 of the application. 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. Clinical skills	Marginal*	Fully Meets Standards
B. Any indication of chemical dependency?	Yes*	No
C. Any indication of malprescribing?	Yes*	No

*Please attach letter of explanation.

Completed By:

Printed Name______________________________ Signed______________________________

Health Profession__________________________ License #______________ State_____________

Date____________________ Phone#________________________ Fax____________________

Email____