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

MEDICAL FACULTY PHYSICIAN FACT SHEET

LICENSURE ELIGIBILITY

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 an accredited program 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. §147.0375 for details.
3. Present evidence satisfactory to the Board that the applicant has been appointed to serve as a faculty member of a medical school accredited by the Liaison Committee of Medical Education or an osteopathic medical school accredited by the American Osteopathic Association.

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 the 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 his/her 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 obligations. 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 licenses 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 become licensed and 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 office with any questions.

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NOTICE

In accordance with Minn. Stat. §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 privileged 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 in the professional use of the doctor's name.
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 federally 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 Minn. Stat. §§ 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. Applicant must not be under license suspension or revocation by the licensing board of the state or jurisdiction in which the conduct that caused the suspension or revocation occurred.

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MEDICAL FACULTY INSTRUCTIONS

Enclosed is the application for a Minnesota medical faculty license. Please review the 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 complete the application in a timely manner. Incomplete applications may be destroyed after six months of inactivity.

ALL OF THE FOLLOWING REQUIREMENTS MUST BE MET:

___ **Application Fee:** Fee of $425.00. *These fees are not refundable and must be in U.S. currency.* Make check payable to the ***Minnesota Board of Medical Practice*****.** Cash will not be accepted. Any cash received will be returned, and processing of your application may be delayed.

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

___ **Name:** The name on the application and medical school diploma must be the same. If there has been a name name change, submit a copy of the documentation, such as a marriage certificate.

___ **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 fall partly upon the photograph and partly upon the form. ***Applicant's signature is required under photograph***.

___ **Identification:** Copy of 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.

___ **Postgraduate Training Certificate (if issued):** 8 ½" x 11" copy of US/Canadian postgraduate certificate(s) issued. 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:** Required for all applicants. If you have had no malpractice suites, write "**NONE"** in the space provided, 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.

___ **Facilities List Form**: List all facilities where you have had medical privileges during the last 10 years. List any facility where you are or have been paid outside the postgraduate training program. If you have had no medical privileges, write **"None,"** sign, and date the form.

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, accredited US/Canadian training, 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 and postgraduate training verification forms 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.

___ **Postgraduate Training:** Submit the Postgraduate Training Verification form to each training program, whether or not it was accredited or completed or a research program. The training programs 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 license is not current is required. Each Board must email, mail or fax directly to the **Minnesota Board of Medical Practice**. Any fees are 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 a digitally certified Self-Query results in a PDF file format which the Board accepts from the applicant in lieu of a paper copy.

___ **Faculty Appointment Letter:** An original letter, addressed to the Board, must be sent **directly** to the Board, on letterhead and signed by the appointing authority, attesting to the requirements of Minnesota Statutes section 147.0375, subdivision 1 (d). *NOTE: A copy of a letter of hire is not sufficient to meet this requirement.*

APPLICATION FOR MEDICAL FACULTY 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. Failure to answer all questions completely and accurately, omission or falsification of material facts, or alteration of 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 public)

Street_____

City_____ State_____ Zip Code_____Country_____

Phone_____ Email (REQUIRED)_____

Applicant Name_____ Last 4 digits of SSN _____ Date_____

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_____ 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)

Military Status. Pursuant to Minn. Stat., 326.56, subd. 2, if you are currently on ***active-duty*** military or have been discharged in the last 6 months, a portion of the application fee will be waived. Please include documentation of your current military status (if active duty) or discharge papers (DD Form 214, if discharged within 6 months) Active Military Service ***does not include*** Army National Guard, the Air National Guard, military reservations, without limitation, military installations, armories, air bases, and facilities owned or controlled by the state for military purposes.

.Do you meet Minn. Stat., 326.56, subd. 2?

◯ No

◯ Yes (the Board will audit documentation provided)

Applicant Name_____ Last 4 digits of SSN _____ Date_____

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_____

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_____

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***. In addition, 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

Applicant Name_____ Last 4 digits of SSN _____ Date_____

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

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.

_____

_____

Applicant Name_____ Last 4 digits of SSN _____ Date_____

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 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 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

_____
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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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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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

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.

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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 emailed or 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 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.