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 ASSISTANT
Verification of Licensure/Registration

This form is for verification of all physician assistant and other healthcare professional licenses or registrations from every board issuing any type of license including training and temporary permit even if license is not current. **Each Board completing the form must email or mail directly to the Minnesota Board of Medical Practice.** Any fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Your Name:______________________________SS#: ____________________

Signature: ______________________________ Date: _________________________

* *

The State Board completes the following information:

It is hereby certified that: ____
(Name of Applicant)

Date of birth: ____
(Month / Day / Year)

Was issued license/registration number: __________________________________

By: ______________________________ On:______________________________
(State) (Month / Day / Year)

Expiration date is:____
(Month / Day / Year)

Issued on the basis of: ____

Disciplinary action ever initiated, pending, or invoked? Yes*______ No ______

Ever voluntarily relinquished license? Yes*______ No ______

State

Print name: _________________________
____

Seal**

Signature: ______________________________
____

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

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