

# CERTIFICATION OF REGISTRATION – MINNESOTA PROFESSIONAL FIRM



**MINNESOTA BOARD OF MEDICAL PRACTICE**  
**335 RANDOLPH AVENUE, SUITE 140**  
**ST. PAUL, MINNESOTA 55102**  
**612-617-2130 or [mn.gov/boards/medical-practice](http://mn.gov/boards/medical-practice)**

FOR BOARD USE ONLY

Hearing Impaired-Minnesota Relay Service  
 Metro Area 651-297-5353  
 Outside Metro Area 1-800-627-3529

**Date of Application:**

Month	Day	Year

APPLICATION #: \_\_\_\_\_  
 CHECK/RECEIPT #: \_\_\_\_\_  
 AMT PAID: \_\_\_\_\_  
 LICENSE #: \_\_\_\_\_

### Instructions to Applicant

Minnesota Statutes Chapter 319B states that no professional firm may furnish professional services within Minnesota until the firm files information with each Board having jurisdiction over the pertinent professional services.

- **Complete form.**
- **Submit documents.** Please include the firm's
  - Certificate of Authority, Statement of Foreign Qualifications, or other organization documents
  - Evidence of filing with the Minnesota Secretary of State
- **Enclose filing fee.** \$100 for initial fee. Make check payable to the MN Board of Medical Practice. Annual reports must be filed on or before January 1<sup>st</sup> of each year along with a \$25 fee.

ACCOUNT CODE	AMOUNT
635040 app	

### Professional Firm

Name of Professional Firm:		Contact Phone Number:	
Street Address:		Email:	
City:	State or Province:	Zip Code:	Country:

Location at which firm is operating or will operate: \_\_\_\_\_

Location where books and records of the firm are maintained: \_\_\_\_\_

Professional services being rendered: \_\_\_\_\_

If this is a foreign firm, as defined under Minn. Stat. §319B.02, Subd. 6, registered under the laws of a state other than Minnesota, state whether the firm is authorized to do business in the State of Minnesota under the provisions of Minn. Stat. Chapter 303.

\_\_\_ Not a foreign firm

\_\_\_ Foreign firm and authorized under Minn. Stat. Chapter 303

**Owners of an Ownership Interest:**

Name	Address	License #

**Persons with Governance Authority within the Firm:**

Name	Address	License #

**Affidavit of Applicant:**

State of: \_\_\_\_\_

County of: \_\_\_\_\_

I swear that I am an owner or employee of the professional firm and duly authorized to make a statement on behalf of the professional firm. I declare that my answers herein are true and correct to the best of my knowledge. I affirm that all employees, agents, and independent contractors, owners, and persons occupying a position with governance authority who are professionals authorized to furnish professional services in this state on behalf of the firm are licensed by this state or otherwise authorized to furnish such professional services.

\_\_\_\_\_  
Signature and Title of Applicant

\_\_\_\_\_  
Please Print Name and Title

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Signature of Notary Public \_\_\_\_\_ My Commission Expires: \_\_\_\_\_