

APPLICATION FOR RESIDENCY PERMIT EXTENSION



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

FOR BOARD USE ONLY

INSTRUCTIONS TO APPLICANT

RESIDENCY PERMIT [MN Statute 147.0391, subd. 1](#) requires a person to have a residency permit while participating in an approved residency program or other Board approved graduate medical education program unless licensed by the Board. A separate residency permit is required for each residency program until the applicant is licensed. The residency permit holder shall submit written notification to the Board within 30 days after termination of participation in a residency program.

The Residency Permit only allows an individual the privilege of functioning in the approved institution setting. The practice of medicine outside such a setting, i.e., insurance physicals, remuneration outside the residency program, etc. may be a violation of the Minnesota Medical Practice Act and may result in the implementation of formal legal action against the violator, or denial of permanent licensure or both.

APPLICATION FEE: \$15.00

APPLICATION #: _____

DEP/LINE # _____

SOURCE CODE	AMOUNT
635017	

YOUR CURRENT FULL LEGAL NAME AND ADDRESS: [MN Statute 13.41, subd. 2](#) requires designated contact information to be PUBLIC and it will be placed on the residency permit and the Medical Board's website. You may change this information in your online services account after your residency permit is issued.

LAST	FIRST	MIDDLE	<input type="checkbox"/> NO MIDDLE NAME	
STREET ADDRESS:				
CITY:	STATE/PROVINCE:	ZIP CODE:	COUNTRY:	EMAIL:
PRIMARY PHONE:	OTHER PHONE	GENDER:	OTHER NAMES:	
DATE OF BIRTH: <small>(MM/DD/YYYY)</small> / /	CITY OF BIRTH:	COUNTY OF BIRTH:	STATE/PROVINCE OF BIRTH:	COUNTRY OF BIRTH:
SOCIAL SECURITY NUMBER:				
<input type="checkbox"/> I do not have a US Social Security number currently but will notify the Board when I obtain a US Social Security Number.				
DRIVERS LICENSE: STATE:		LICENSE NUMBER:		<input type="checkbox"/> I do not have a driver's license

CURRENT MINNESOTA RESIDENCY PERMIT FOR EXTENSION

RESIDENCY PERMIT # _____ REASON FOR EXTENSION _____

I, _____ swear that I am the person described and identified. I have carefully read the information 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 may constitute cause for denial, suspension, or revocation of my residency permit or of any later license to practice medicine in Minnesota. I understand that I am subject to the reporting obligations of [MN Statute 147.111](#).

Signature of Applicant: _____ Date: _____

APPROVED RESIDENCY TRAINING PROGRAM EXTENSION FORM

APPLICANT: The section below needs to be completed by the residency program in Minnesota.

Online Application: Enter the information below in the residency program information section and upload completed form to your online application.

Paper Application: Mail completed form with your paper application and fee to the Medical Board.

RESIDENCY PROGRAM TO COMPLETE BELOW:

It is hereby certified that: _____ will be extending
(resident applicant's name)
participation in the _____ specialty residency training
at: _____ residency program located at _____, Minnesota
(city)
from original permit end date on: ____/____/____ to new extension date ending on: ____/____/____.
(mm/dd/yyyy) (mm/dd/yyyy)

The program meets the requirements of [MN Statute 147.0391](#) as of the dates above. I understand that the residency program faculty is subject to the reporting obligations of [MN Statute 147.111](#) with respect to this resident, if they are granted a residency permit.

Director/Dean or Authorized Person of Residency Program
Name Printed: _____
Name Signed: _____
Date: _____

*RESIDENCY PROGRAM STAMP or SEAL**

*If there is no stamp or seal, attach letter of explanation on letterhead to use in place of stamp or seal.

RESIDENCY PERMIT 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. 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 been convicted 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 _____