APPLICATION FOR RESIDENCY PERMIT

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: $20.00
Cash will not be accepted.
Any cash received will be returned, and processing of your application may be delayed.

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 ☐ NO MIDDLE NAME

STREET ADDRESS:

CITY:	STATE/PROVINCE:	ZIP CODE:	COUNTRY:	EMAIL:

PRIMARY PHONE:	OTHER PHONE	GENDER:	OTHER NAMES:

DATE OF BIRTH: (MM/DD/YYYY) / /	CITY OF BIRTH:	COUNTY OF BIRTH:	STATE/PROVINCE OF BIRTH:	COUNTRY OF BIRTH:

SOCIAL SECURITY NUMBER:

☐ 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: ☐ I do not have a driver's license

MEDICAL EDUCATION

NAME OF SCHOOL:	CITY:	STATE OR PROVINCE:	COUNTRY:	DATE COMPLETED: (MM/DD/YYYY) / /

MINNESOTA RESIDENCY PERMIT HISTORY

HAVE YOU EVER HAD A RESIDENCY PERMIT IN MINNESOTA BEFORE? ☐ NO ☐ YES, GIVE RESIDENCY PERMIT #_____

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 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 on 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: _____
(resident applicant's name)

will be participating in the _____ specialty residency training

at: _____ residency program located at:

_____, Minnesota to start on: ____/____/_____ and end on: ____/____/_____.
(city) (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.

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

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 Adress_____

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.

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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 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_____