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

APPLICATION TO PRACTICE TELEMEDICINE

Telemedicine is the practice of medicine as defined in MN Stat. § 147.081 subdivision 3 when the physician is not in the physical presence of the patient.

To be eligible for telemedicine registration, a physician must be licensed in the state from which telemedicine services are provided and must not have ever had a license to practice medicine revoked or restricted in any state or jurisdiction.

A physician registered in Minnesota to provide telemedicine services cannot open an office in Minnesota, cannot meet with patients in Minnesota, and cannot receive calls in Minnesota from patients.

- Enclose $175.00 with the application ($100 initial application fee and $75.00 annual fee)
  These fees must be in U.S. currency. Make checks payable to the Minnesota Board of Medical Practice.

- Obtain a verification from every state or jurisdiction where you are currently or have ever been licensed.

- Provide a written explanation on any negative licensing actions taken in any state or jurisdiction

- Provide a notarized, legible photocopy of a state-issued driver's license.

For more information about telemedicine registration in Minnesota or for a copy of the telemedicine law or Medical Practice Act, please consult our home page at **www.bmp.state.mn.us**

Note: The telemedicine registration application is now available online at https://bmp.hlb.state.mn.us/#/Login. Please consider using the online application if possible.

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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

DATE OF APPLICATION:

MONTH	DAY	YEAR

FOR BOARD USE ONLY

APPLICATION #: _____

CHECK/RECEIPT #: _____

AMT PAID: _____

APPROVAL DATE: _____

REGISTRATION #: _____

ACCOUNTCODE	AMOUNT
635000 app	
635001 reg	

INSTRUCTIONS TO APPLICANT

1. Answer all questions completely, accurately, and legibly or the application will be returned.
2. All addresses must include zip code if requested on the application.
3. Enter all dates as MONTH-DAY-YEAR.
4. The application fee is not refundable.
5. Failure to answer all questions completely and accurately, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.
6. Incomplete applications may be destroyed after six months of inactivity.
7. Enclose a check for $175.00 in U.S. currency with the application payable to the Minnesota Board of Medical Practice.

YOUR CURRENT NAME AND ADDRESS (PUBLIC)

FULL LEGAL NAME: LAST	FIRST	MIDDLE

STREET ADDRESS:

CITY:	STATE OR PROVINCE:	ZIP CODE:	COUNTRY:

HOME PHONE:	BUSINESS PHONE:	GENDER: ☐ MALE ☐ FEMALE	OTHER NAMES:

SOCIAL SECURITY OR ALIEN REGISTRATION NUMBER:	EMAIL ADDRESS:

ADDRESS (PRIVATE)

STREET ADDRESS:

CITY:	STATE OR PROVINCE:	ZIP CODE:	COUNTRY:

RECORD OF BIRTH				
DATE OF BIRTH: Mo/Day/Year	CITY OF BIRTH:	COUNTY OF BIRTH:	STATE/PROVINCE OF BIRTH:	COUNTRY OF BIRTH:

IDENTIFYING CHARACTERISTICS			
HEIGHT (ft./in.):	WEIGHT (lbs):	COLOR HAIR:	COLOR EYES:
IDENTIFYING MARKS:			

MEDICAL DIPLOMA						
DOCTOR OF: ❑ MEDICINE ❑ OSTEOPATHY	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE	ZIP:	COUNTRY:	DATE COMPLETED Mo/Day/Year

STATES/PROVINCES/COUNTRIES IN WHICH YOU ARE OR HAVE EVER BEEN LICENSED		
STATE/PROVINCE/COUNTRY	LICENSE NUMBER	DATE ISSUED (Mo/Day/Year)

1. You must be licensed without restriction in the state from which you provide telemedicine services. Please specify state from which you provide telemedicine services. _____	
2. Has your license to practice medicine in any state or country ever been voluntarily or involuntarily (i.e. by Medical Board Order or any other form of disciplinary action) revoked through the disciplinary process, suspended, restricted, or conditioned by a Medical Board or other licensing authority? **If your license has been revoked, suspended or restricted in any state or jurisdiction, you are not eligible for telemedicine registration.**	Y N
3. What is your specialty? _____	
4. Are you certified by the American Board of Medical Specialties?	Y N

Paste a recent photo, front-view passport-type photo in this square

AFFIDAVIT OF APPLICANT:

STATE OF: _____

COUNTY OF: _____

NOTARY SEAL

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; that I intend to provide interstate telemedicine services in Minnesota.

I hereby authorize all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including 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 registration to practice telemedicine 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.

I understand that I must immediately notify the Board of any restrictions placed on my license in any state or jurisdiction. I agree to be subject to state laws, the state judicial system and the board with respect to providing medical services to Minnesota residents. (MN State. §147.032 Subd 1 (c,d)). I understand that I am subject to the reporting obligations of MN Stat. §147.111 and that I must comply with MN Stat. §144.335, Access to Health Records.

Sworn to before me this _____ day of _____ , _____ .

_____

Signature of Notary Public

_____

Signature of Applicant

My Commission Expires: _____

RIGHTS OF SUBJECTS OF DATA

This information 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 requirements for registration. The information is classified as private while your application is pending or if your application is denied, and is public unless indicated otherwise if your registration 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, and/or omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently registered 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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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 mail 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. Verifications through VeriDoc are also accepted. 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.

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