MINNESOTA
BOARD OF SOCIAL WORK

2829 University Ave SE Ste 340
Minneapolis MN 55414-3239
612-617-2100 | 612-617-2103 (fax)
social.work@state.mn.us | mn.gov/boards/social-work

Protecting the Public

REGISTRATION TO PROVIDE TELEHEALTH DURING COVID-19 EMERGENCY UNDER MINNESOTA EMERGENCY EXECUTIVE ORDER 20-28

INFORMATION & INSTRUCTIONS

- **MINNESOTA EMERGENCY EXECUTIVE ORDER 20-28:** Under the authority of Emergency Executive Order 20-28, pursuant to Minnesota Statutes section 12.42, and in response to the Minnesota COVID-19 Peacetime State of Emergency, out-of-state mental healthcare providers who hold a license, certificate, or other permit in good standing issued by a state of the United States or the District of Columbia may be authorized to provide time-limited telehealth to meet the needs of this emergency.

  This authorization applies only to healthcare providers who would otherwise be required to obtain a license from one or more of the following Minnesota health-related or regulatory boards: Behavioral Health and Therapy, Marriage and Family Therapy, Psychology, Social Work. Before rendering any such aid in this state, such healthcare providers shall (a) complete the registration form required by the appropriate Minnesota health-related licensing or regulatory board, and (b) receive from the appropriate Minnesota health-related licensing board and acknowledgement of receipt of the registration form.
- **CLASSIFICATION OF DATA:** All information provided on this form is classified as public data under the Minnesota Government Data Practices Act.

STEP 1:

- **COMPLETE REGISTRATION FORM:** This form may be completed electronically or printed. *Incomplete forms will not be accepted.*

STEP 2:

- **ATTACH COPY OF CURRENT LICENSE/CREDENTIAL:** Attach a copy of your current license/credential demonstrating authorization to practice behavioral health in a state or jurisdiction other than Minnesota.
- **ATTACH COPY OF PHOTO IDENTIFICATION:** Attach a copy of current form of identification (e.g. state issued driver's license, US passport, employer/student identification).

STEP 3:

- **SUBMIT REGISTRATION FORM AND COPY OF LICENSE/CREDENTIAL AND PHOTO ID:** Submit completed form and copy of your current license/credential and photo ID **by email or US mail to the** applicable address listed at the top of this form.

DATA PRACTICES WARNING

The Board is seeking data from you which is considered public data under the Minnesota Government Data Practices Act (Minn. Stat. chapter 13). (1) You are not legally required to provide the information requested, but failure to do so will result in your ineligibility to provide telehealth services in Minnesota pursuant to Minnesota Emergency Executive Order 20-28. (2) If you supply the data requested and it shows a violation of any of the statutes or rules enforced by the Board, you may be subject to disciplinary or other action by the Board. In addition, falsification or omission of information may be used by the Board as a basis for disciplinary action. (3) The data which you supply will be accessible to Board staff and may also be released to other persons or governmental entities that have statutory authority to review the data, investigate specific conduct, or take appropriate legal action, such as Board members, and the Minnesota Office of the Attorney General staff. If the Board institutes a formal disciplinary action against you, the information you supply could become public.

REGISTRANT DATA				
LAST NAME:	**FIRST NAME:**		**MIDDLE NAME:**	
PUBLIC MAILING ADDRESS:				**TYPE** *(check one)*: ☐ Home ☐ Business ☐ Other
CITY:	**COUNTY:**	**STATE:**	**ZIP CODE:**	
PUBLIC PHONE NUMBER:		**TYPE** *(check one)*: ☐ Business ☐ Home ☐ Mobile ☐ Other		
PUBLIC EMAIL ADDRESS:				
NAME OF STATE BOARD OR AGENCY ISSUING CURRENT LICENSE:				
LICENSE TYPE:	**LICENSE NUMBER:**		**STATE:**	

REPORT OTHER HEALTH-RELATED LICENSES HELD (CURRENT OR EXPIRED) AND ISSUING STATE:	
LICENSE TYPE:	*STATE:*
1.	
2.	
3.	
4.	

ACKNOWLEDGEMENT & ATTESTATION

ATTESTATION OF REGISTRANT:

1. I attest my license/credential in my home state, under which I intend to practice in Minnesota, is current and in good standing.
2. I attest there are no current disciplinary or corrective action orders against my license(s).
3. I understand the authority to practice telehealth In Minnesota is limited to Executive Order 20-28 and ends when the Minnesota Peacetime State of Emergency ends or is rescinded by a proper authority. Authorization begins at the time the Board acknowledges the submission of this completed form with copy of my current license credential, and photo identification.
4. I understand the practice authority granted under Emergency Executive Order 20-28 is limited to provision of services by telehealth to meet the needs of this emergency, and I attest I possess the required competencies.
5. I attest I am familiar with the Minnesota Health Licensing Board regulations, Board of Behavioral Health and Therapy, Board of Marriage and Family Therapy, Board of Psychology, and Board of Social Work, under which I intend to practice.
6. I attest that all information provided in this registration is true and correct. I understand that making a false statement or misrepresentation to the Board is grounds for the Board to take disciplinary action.
7. I attest that I will notify each Minnesota client, when commencing telehealth services, of the (a) jurisdictions in which I am licensed, and (b) contact information for the designated Minnesota Board with which I am registered.
8. I understand that by rendering such aid in Minnesota, as an out-of-state healthcare provider, I submit to the jurisdiction of the Minnesota health-related licensing and regulatory board under which I have registered.

SIGNATURE OF REGISTRANT *(electronic signature acceptable)*:	**DATE:**

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CLEAR FORM

PRINT FORM