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

DATE OF APPLICATION:

MONTH	DAY	YEAR

FOR BOARD USE ONLY

APPLICATION #: ____________

DEP/LINE # ____________

PERMIT #: ____________

APPROVAL DATE: ____________

PREV APP DATE: ____________

PREV APP DATE: ____________

SOURCE CODE	AMOUNT
635017	

INSTRUCTIONS TO APPLICANT

Minnesota Statute 147.0391 RESIDENCY PERMIT 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 initial application fee is $20. For an extension of an existing residency permit, please refer to the extension request form. The following must be completed by the student and the licensed hospital making available an approved hospital training program and forwarded to the offices of this Board. Answer all questions completely and accurately or the application will be returned.

YOUR CURRENT NAME AND ADDRESS

FULL LEGAL NAME: LAST	FIRST	MIDDLE		
STREET ADDRESS:				
CITY:	STATE/PROVINCE:	ZIP CODE:	COUNTRY:	EMAIL:
HOME PHONE:	OTHER PHONE:	GENDER ❑ MALE ❑ FEMALE	OTHER NAMES:	
DATE OF BIRTH: (MO/DAY/YEAR) / /	CITY OF BIRTH:	COUNTY OF BIRTH:	STATE/PROVINCE OF BIRTH:	COUNTRY OF BIRTH:
SOCIAL SECURITY NUMBER:	**OR**	ALIEN REGISTRATION NUMBER:		

MEDICAL DIPLOMAS

BACHELOR OF: ☐ MEDICINE ☐ OSTEOPATHY	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE:	COUNTRY:	DATE COMPLETED: (MO/DAY/YEAR) / /
DOCTOR OF: ☐ MEDICINE ☐ OSTEOPATHY	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE:	COUNTRY:	DATE COMPLETED: (MO/DAY/YEAR) / /

RESIDENCY PERMIT HISTORY

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

NOTE: 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.

I, ____ swear that I am the person described and identified. I have carefully read the questions 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: ________________

RIGHTS OF SUBJECTS OF DATA

Under Minnesota Statutes 13.41, subdivision 2 (1984), information you provide in this application, except for your name and address, is classified as private, that is, accessible only to you, the staff and members of the Board, the Board's counsel, and persons you designate while you remain an applicant. When you are granted a residency permit, the information in your file related to your residency permit is classified as public under Minnesota Statutes 13.41, subdivision 4 (1984). The purpose and intended use of this information is to enable the Board to determine whether you meet statutory and rule requirements for a residency permit. You are not legally required to provide this information, but you cannot be granted a residency permit without doing so.

RESIDENCY CERTIFICATION

NOTE: This section is to be completed by the residency program in Minnesota, only following completion of the foregoing information by the student.

It is hereby certified that: ______________________________________
(Please Print)

Is currently engaged in a ______________________________________ specialty residency
(specify specialty)

training program for ____________ years/months at: ______________________________________

health facility located at: ______________________________________,
(Full Address)

commenced: ________/________/________ anticipated ending: ________/________/________.
(MO/DAY/YEAR) (MO/DAY/YEAR)

that said program meets the requirements of MN Statute 147.0391 as of the dates above; and that the statements certified on the reverse hereof by the student delineated above, are true and correct to the best knowledge and belief of this facility. I understand that the residency program faculty is subject to the reporting obligations of MN Statute 147.111 with respect to this student, if she/he is granted a residency permit.

Director/Dean of Medical Education

Name Printed: Annie Sadosty, MD, Designated Institutional Officer

Name Signed: ______________________________

Date: ______________________________

HEALTH FACILITY 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

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.

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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: ________________

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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____________