APPLICATION FOR CAMP DOCTOR REGISTRATION

MINNESOTA BOARD OF MEDICAL PRACTICE
UNIVERSITY PARK PLAZA
2829 UNIVERSITY AVENUE SE, SUITE 400
MINNEAPOLIS, MINNESOTA 55414-3246
612-617-2130 or www.bmp.state.mn.us

Hearing Impaired-Minnesota Relay Service
Metro Area 297-5353
Outside Metro Area 1-800-627-3529

INSTRUCTIONS TO APPLICANT

MN Stat. §147.09 (3) allows physicians to treat patients participating in camp activities (outdoor recreation) in Minnesota after registering with the Board. To be eligible for camp doctor registration, a physician must be licensed in another state and obtain a verification from the state where you are currently practicing. There is no fee for this registration.

1. Enter all dates as Month/Day/Year.
2. Answer all questions completely and accurately.
3. Incomplete applications will be returned for completion.

Consult our home page at www.bmp.state.mn.us for more information about camp doctor (outdoor recreation) registration in Minnesota or for a copy of the complete statutes.

FOR BOARD USE ONLY

APPLICATION #: _____

REG #: _____

APPROVAL DATE: _____

SOURCE CODE	AMOUNT
	No Fee

DATE OF APPLICATION: _____ / _____ / _____
Month Day Year

YOUR CURRENT NAME AND ADDRESS

FULL LEGAL NAME: LAST	FIRST	MIDDLE
STREET ADDRESS:		

CITY:	STATE OR PROVINCE:	ZIP CODE:	COUNTRY:

HOME PHONE:	WORK PHONE:	GENDER ❑ MALE ❑ FEMALE	OTHER NAMES:

SOCIAL SECURITY #:	DATE OF BIRTH: (Month-Day-Year)	CURRENTLY PRACTICING IN THE STATE OF:	LICENSE #

MEDICAL SCHOOL

NAME OF SCHOOL:	CITY:	STATE OR PROVINCE	COUNTRY:	DATE OF GRADUATION (Month-Day-Year)

CAMP REGISTRATION

CAMP (OUTDOOR RECREATION FACILITY) WHERE REGISTRATION WILL BE USED:	FOR THE PERIOD: (Month-Day-Year)	
	START DATE:	END DATE:

I have read Minnesota Statute §147.09 (3) and will comply with the provision therein.

Signature _____ Date _____

MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
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MN Relay Service for Hearing Impaired (800) 627-3529

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): O Felony O 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 _____ Date _____

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VERIFICATION OF MEDICAL LICENSE

(for Minnesota Camp Doctor Applicants)

This form is for verification of your medical license where you are currently practicing medicine. The Board must complete this form and 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.

Name_____ SS#_____

Signature_____Date_____

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THE STATE BOARD WHERE YOU ARE LICENSED, MUST COMPLETE THE FOLLOWING INFORMATION AND MAIL DIRECTLY TO THE MINNESOTA BOARD OF MEDICAL PRACTICE:

IT IS HEREBY CERTIFIED THAT: (Name of Applicant)_____

DATE OF BIRTH: (Month, Day, Year) _____

WAS ISSUED LICENSE NUMBER: _____

BY: (State)_____ **ON:** (Month, Day, Year) _____

EXPIRATION DATE IS: (Month, Day, Year)_____

ISSUED ON THE BASIS OF: (Exam) _____

DISCIPLINARY ACTION EVER INITIATED, PENDING, OR INVOKED*: (Yes/No) _____

EVER VOLUNTARILY RELINQUISHED LICENSE*: (Yes/No)_____

ANY DEROGATORY INFORMATION WHICH YOU CAN RELEASE*: (Yes/No)_____

Print Name_____

Seal** Signature_____

Title _____

Date_____

***If yes, please attach letter of explanation on letterhead.**
****If there is no seal, attach letter of explanation on letterhead.**

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