APPLICATION FOR COMPETITIVE ATHLETIC EVENT PHYSICIAN REGISTRATION

MINNESOTA BOARD OF MEDICAL PRACTICE
UNIVERSITY PARK PLAZA
2829 UNIVERSITY AVENUE SE, SUITE 500
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

FOR BOARD USE ONLY

APPLICATION #: __________

CHECK/RECEIPT #: __________

AMT PAID: __________

REG #: __________

APPROVE DATE: __________

SOURCE CODE	AMOUNT
635038	
	.

DATE OF APPLICATION:

MONTH	DAY	YEAR

INSTRUCTIONS TO APPLICANT

1. Enter all dates as Month/Day/Year.
2. Please type or print and answer all questions completely and accurately. 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.
3. Application fee is $50.00. This fee is not refundable and must be in U.S. currency. Please make checks payable to the **Minnesota Board of Medical Practice.**
4. Incomplete applications will be returned for completeness.

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:	LICENSED IN THE STATE OF:	LICENSE #

MEDICAL SCHOOL

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

ATHLETIC EVENT

NAME AND LOCATION OF ATHLETIC EVENT:	FOR THE PERIOD: (Month-Day-Year)	
	START DATE:	END DATE:

I have read Minnesota Statute §147 and will comply with the provision therein.

Signature ____________________ Date ____________________