MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone 612-617-2130 • Fax 612-617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired 800-627-3529

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 $192.50 with the application ($110 initial application fee and $82.50 annual fee) **These fees must be in U.S. currency. Make checks payable to the Minnesota Board of Medical Practice.**

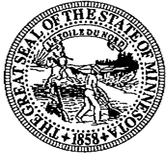
- Obtain a verification from every state or jurisdiction where you are currently or have ever been licensed.

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

- Physicians certified by the American Board of Medical Specialties must enclose a notarized copy of their certificate

- 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**



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IMPORTANT

E-licensing Surcharge

In 2009, the legislature enacted MN Statute 16E.22 which requires state agencies to collect a temporary surcharge of 10% of no less than $5.00 and no more than $150.00 for the initial license application and license renewal fees for business, commercial, professional, and occupational licenses. These fees must be collected whether the application is made by paper or online and must be collected from July 2009 through June 2015 for the Minnesota Office of Enterprise Technology to fund a statewide electronic licensing system. Since 2009, the Board of Medical Practice has utilized our reserve fund to meet this requirement on our licensee's behalf, but our reserve fund is now depleted and we are obligated by law to collect the surcharge directly from our applicants and licensees.

Effective November 1, 2010, the following fees (including the e-licensing surcharge) must be submitted with the initial application or the application will be returned. The fees below do not include the temporary permit fee. There is no surcharge for a temporary permit.

Profession	Fee*
Acupuncture	$330
Athletic Trainer	$165
Naturopathic Doctor	$385
Physician	$431.20
Physician Assistant	$280.50 with prescribing
	$258.50 without prescribing
Respiratory Therapist	$209
Telemedicine	$192.50
Traditional Midwife	$220

*Includes initial application fee, annual fee, and e-licensing surcharge.

IMPORTANT

APPLICATION TO PRACTICE TELEMEDICINE

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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

DATE OF APPLICATION:

MONTH	DAY	YEAR

FOR BOARD USE ONLY

APPLICATION #: ____________
CHECK/RECEIPT #: ____________
AMT PAID: ____________
APPROVAL DATE: ____________
REGISTRATION #: ____________

ACCOUNTCODE	AMOUNT
635000 app	
635001 reg	
513122 sur	

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 $192.50 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:	NAME OF SCHOOL:	CITY:	STATE OR PROVINCE	ZIP:	COUNTRY:	DATE COMPLETED Mo/Day/Year
☐ MEDICINE ☐ OSTEOPATHY						

STATES/PROVINCES/COUNTRIES IN WHICH YOU ARE OR HAVE EVER BEEN LICENSED

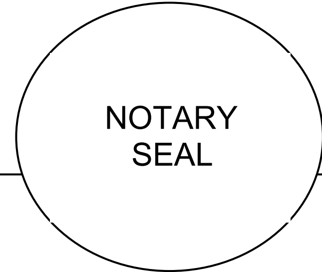
STATE/PROVINCE/COUNTRY	LICENSE NUMBER	DATE ISSUED (Mo/Day/Year)

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? (If so, please submit notarized copy of certificate.)	Y N

AFFIDAVIT OF APPLICANT:

STATE OF: ____________________

COUNTY OF: ____________________



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.

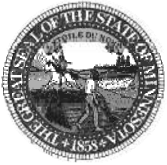
Sworn to before me this ________ day of __________ , __________ .

____
Signature of Notary Public

My Commission Expires: ________________

____
Signature of Applicant

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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VERIFICATION OF LICENSURE

(for Minnesota Telemedicine Applicants)

This form is for verification of all medical licenses from any state or jurisdiction issuing any type of medical license including telemedicine, 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.

Print Name____ SS#________________________

Signature____ Date________________________

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)________________________

PHYSICAL IDENTIFICATION	
A copy of licensure application which includes this information will meet this requirement. Verification cannot be processed without it.	
DESCRIPTION	PHOTOGRAPH
Height: ____________ Weight: ____________ Eye color: ____________ Hair Color: ____________ Physical Marks: ____________ Gender: ____________	(Attach to verification)

SEAL**

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.

01/03