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

ACUPUNCTURIST FACT SHEET

History

The Minnesota Legislature enacted a law in 1995 establishing a licensure system for acupuncturists. The Board of Medical Practice enforces the requirements of the acupuncturist licensure system and provides information to consumers and other interested persons.

Acupuncture Advisory Council

The Acupuncture Advisory Council was appointed by the Board of Medical Practice to advise the Board on issues regarding acupuncturist licensure standards, enforcement of the practice act, and complaint review. The Council is composed of seven members: four acupuncture practitioners, one physician who also practices acupuncture, one chiropractor who is certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), and one public member who has received acupuncture treatment as a primary therapy from a NCCAOM certified acupuncturist.

Licensure Required

It is unlawful for any person to engage in the practice of acupuncture without a valid license after June 30, 1997. Each licensed acupuncture practitioner shall conspicuously display the license in the place of practice. A person licensed under the Acupuncture Practice Act shall use the title of licensed acupuncturist or L.Ac. All unlicensed persons are prohibited from using the words or letters licensed acupuncturist, Minnesota licensed acupuncturists or any other words, letters, abbreviations, or insignia indicating or implying that the person is an acupuncturist without a license issued under the Acupuncture Practice Act. Unlicensed persons holding themselves out as an acupuncturist are guilty of a misdemeanor. A student attending an acupuncture training program must be identified as a student acupuncturist.

Exemptions

The following persons are exempt from the acupuncture license requirement:

- Physicians licensed in Minnesota
- Osteopaths licensed in Minnesota
- Chiropractors licensed in Minnesota
- Persons studying in an acupuncture advisory council approved program providing their acupuncture practice is supervised by a licensed acupuncturist
- A visiting acupuncturist practicing and teaching acupuncture within an instructional setting registered with the Minnesota higher education coordinating board. This person may practice without a license for up to one year, with two one-year extensions permitted.
- A visiting acupuncturists whose sole purpose for visiting state if to provide a tutorial or workshop for 30 days or less per calendar year.

Licensure Requirements

- **General Licensure.** To establish eligibility for licensure, an applicant must be currently NCCAOM certified.
- **Licensure by Reciprocity.** Applicant must have current and unrestricted license or certificate from another jurisdiction with requirements which meet or exceed Minnesota licensure requirements.

Scope of Practice

The scope of practice of acupuncturists includes, but is not limited to: 1) using Oriental medical theory to assess and diagnose a patient and 2) using Oriental medical theory to develop a plan to treat a patient. The acupuncturists must refer patients with a potentially serious disorder to other health care practitioners. The acupuncturists shall request a consultation or written diagnosis from a licensed physician for patients with potentially serious disorders.

Practice Standards

Prior to treatment of a patient, an acupuncture practitioner shall ask whether the patient has been examined by a health care professional

Continuing Education

Licensees issued an acupuncture license under the general requirements must provide documentation of current NCCAOM certification. Licensees issued an acupuncture license by reciprocity or by equivalency during transitional period must meet the same NCCAOM professional development activity requirements as those licensed under the general requirements.

Renewal Cycle

Licensure must be renewed annually on or before June 30 of each year. Renewal notices are sent approximately 45 days prior to expiration. It is the acupuncturist's responsibility to keep the Board advised of their current address. The Board is obligated to mail the renewal application to the address on file. Failure to receive the renewal documents does not relieve acupuncturists of their renewal obligation.

Inactive Licensure Status

A license may be placed in formal inactive status upon application to the Board and payment of $50 fee and may be reactivated by licensee upon application to the Board.

The Board will cancel a license for nonrenewal if the license has not been renewed within two annual renewal cycles. Acupuncturists wishing to practice in Minnesota again once a license has been canceled for nonrenewal must obtain a new license by reapplying and fulfilling all requirements in existence at time of reapplication.

If any part of this Fact Sheet conflicts with the Minnesota rules or laws, the rules or laws take precedence. It is your responsibility to understand and comply with the regulations. Please call the Board offices if you have any questions.

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ACUPUNCTURIST
Instructions

Enclosed is your application for an Acupuncturist license. Please thoroughly review these materials before submitting your application. Any processing fees incurred are your responsibility. The Board reserves the right to reject any outdated applications submitted; therefore, it is recommended that you use the application in a timely manner. Incomplete applicant files will be destroyed after six months of inactivity.

Applications for an Acupuncturist license received on and after January 1, 2019: MUST include submission of $333.25 ($33.25 criminal background check, $150 application and $150 annual licensure fee).

Methods of Licensure

The statutes establish eligibility for registration by two different avenues. Applicants must select one and indicate choice on the application form. All applicants must submit a completed application and appropriate fees.

General Licensure Requirements

- Verification of a valid and current NCCAOM certificate

Licensure by Reciprocity Requirements

- Verification of current and unrestricted license from another state requiring a current and valid NCCAOM certificate
- Verification of a valid and current NCCAOM certificate

The following requirements must be sent directly to the Minnesota Board from the facility/person completing the form:

- ***All* verification forms.** These forms must be submitted before your application is complete. It is your responsibility to make sure these forms are completed and received by our office. The Board must receive separate verification form completed by each state board where you have ever held a health care professional license/registration.
- **NCCAOM certification.** NCCAOM offers *Exam Results and Certification Verification* through an online portal. Visit https://www.nccaom.org/state-licensure/state-verification/ to login. Paper requests are no longer being accepted.
- **Recommendations** from two acupuncturists or other health care professionals who are knowledgeable re: your professional conduct and character and are not a family member.

In addition to the documentation requirements set forth under the general or reciprocity registration requirements, all of the following requirements must be met or the entire application will be returned:

- Non-refundable $333.25 fee ($33.25 criminal background check, $150 application and $150 annual licensure fee). Make checks payable to the **Minnesota Board of Medical Practice.**
- Account for all your time since graduation from high school to the date of application or ten years, whichever is less. During continuous years of education, periods of three months or less (summer break) need not be accounted for.
- The name on the application and the name on the certificate must be the same. If there has been a name change, submit a *notarized* copy of the supporting documentation, e.g. marriage license.
- A full face, recent, 2x3" photograph must be affixed as indicated on the application and *notarized* as a true likeness.

- *Notarized* copy of NCCAOM certificate.
- Any other information requested by the Board.

Application Fees

Please be aware that all fees are non-refundable. Fees submitted will not be refunded if it is determined that you are not eligible for registration.

Permanent Licensure Fee: $333.25 ($33.25 criminal background check + $150 application + $150 annual)

This fee must be sent with a completed Application for Licensure form.

Annual Fee: $150

To be paid by all licensed acupuncturists annually. The first renewal fee will be pro-rated.

How to Apply

If you qualify for registration and would like an application or if you have specific questions about the application process and would like to talk to someone, please call the Board at 612-617-2130. Address all written correspondence to:

MN Board of Medical Practice – AP Registration
University Park Plaza
2829 University Ave SE – Suite 500
Minneapolis, MN 55414-3246

Applicants are required to submit written notification to the Board within 30 days of any name or address change. The law takes precedence over any conflicts between these instructions and the law.

APPLICATION FOR ACUPUNCTURIST LICENSE

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: _____

REGISTRATION #: _____

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. Have attached forms completed and submitted to our office, where applicable.
4. Read the attached rules regarding Acupuncture Licensure.
5. See the attached Licensure Instructions for information regarding fees to be submitted with your application.
6. The name you enter must exactly match the name on your Acupuncture License certificate or documentation of formal name change must be submitted.
7. The application fee is not refundable.
8. Incomplete applications will be destroyed after six months inactivity.

ACCOUNT CODE	AMOUNT
635042 (lic)	
635043 (app)	
635064 (cbc)	

YOUR CURRENT NAME AND ADDRESS: Minn. Stat. 13.41, Subd. 2 requires designated contact information to be PUBLIC and it will be placed on license and Board website. You may change this information online, upon licensure, by following instruction letter issued at that time.

FULL LEGAL NAME: LAST	FIRST	MIDDLE

STREET ADDRESS:

CITY:	STATE OR PROVINCE:	ZIP CODE:	COUNTRY:

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

SOCIAL SECURITY OR ALIEN REGISTRATION NUMBER:

RECORD OF BIRTH

BIRTHDATE (Mo/Day/Year) / /	CITY OF BIRTH:	STATE OF BIRTH:	COUNTRY OF BIRTH:

NCCAOM INFORMATION (*)

DATE OF CERTIFICATION (Mo/Day/Year) / /	CERTIFICATION NUMBER:	EXPIRATION DATE (Mo/Day/Year) / /

(*) Attach Notarized Copy of National Certification Commission for Acupuncture and Oriental Medicine Certificate (NCCAOM)

BASIS FOR APPLICATION (CHECK ONE)

☐ GENERAL ☐ RECIPROCITY

PRELIMINARY EDUCATION

NAME OF HIGH SCHOOL:	CITY:	STATE OR PROVINCE:	ZIP CODE:	FROM DATE:	TO DATE:
NAME OF COLLEGE:	CITY:	STATE OR PROVINCE:	ZIP CODE:	FROM DATE:	TO DATE:
TYPE OF DEGREE:	NAME OF ISSUING SCHOOL:	CITY:	STATE OR PROVINCE:	DATE DEGREE RECEIVED:	

ACUPUNCTURE EDUCATION

INSTITUTION	CITY	STATE	ZIP CODE	FROM DATE Month/Day/Year	TO DATE Month/Day/Year	DEGREE/ CERTIFICATE

OTHER EDUCATION AND TRAINING

INSTITUTION	CITY	STATE	ZIP CODE	FROM DATE Month/Day/Year	TO DATE Month/Day/Year	DEGREE/ CERTIFICATE

STATE/PROVINCES/COUNTRIES IN WHICH YOU ARE OR HAVE BEEN LICENSED OR REGISTERED
List all health professional licenses

State/Province/Country	Health Profession	License/Registration Number	Date Issued Month/Day/Year	Exam

*NCCAOM exam Reciprocity

DRIVERS LICENSE

STATE:	LICENSE NUMBER:

ACTIVITIES

LIST BELOW, IN CHRONOLOGICAL ORDER, ALL ACTIVITIES INCLUDING POST-GRADUATE TRAINING, HOSPITAL OR CLINIC AFFILIATIONS, AND PERIODS OF UNEMPLOYMENT. ACCOUNT FOR *ALL TIME* SINCE GRADUATION FROM HIGH SCHOOL OR 10 YEARS AGO(WHICHEVER IS LESS). ATTACH A SEPARATE PAGE, IF NECESSARY.

FROM DATE	TO DATE	POSITION	
NAME OF INSTITUTION:			
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

FROM DATE	TO DATE	POSITION	
NAME OF INSTITUTION:			
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

FROM DATE	TO DATE	POSITION	
NAME OF INSTITUTION:			
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

FROM DATE	TO DATE	POSITION	
NAME OF INSTITUTION:			
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

FROM DATE	TO DATE	POSITION	
NAME OF INSTITUTION:			
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

FROM DATE	TO DATE	POSITION	
NAME OF INSTITUTION:			
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

FROM DATE	TO DATE	POSITION	
NAME OF INSTITUTION:			
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

FROM DATE	TO DATE	POSITION	
NAME OF INSTITUTION:			
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

Except for questions 1-4, please answer all questions by selecting Yes or No and provide an explanation when requested. Questions 1-4 do not have "No" as an option for confidentiality reasons. If you have a condition addressed by questions 1-4 and you are NOT participating in Health Professionals Services Program (HPSP) for monitoring of the condition, you must answer "Yes" to the applicable questions(s). If you do not have this condition, OR if you are participating in HPSP for monitoring of this condition, do not answer the applicable question(s). For questions 1-2, the terms "impaired" and "limited" include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders or conditions, or chemical dependency or chemical abuse. The purpose and intended us of this information is to enable the Board to determine whether you meet statutory and rule requirements for licensure. This information is classified as private while your application is pending and public after your renewal is granted. Exception: "Yes" answers are confidential during any investigation and private thereafter. This information will NOT be included in the profiling. If responses to questions change during the time your application is pending, you must make the board aware of the new information.

Y

1. Is your cognitive, communicative, or physical ability to engage in the practice of acupuncture with reasonable skill and safety been impaired or limited in any way? Please describe.

Y N 1a. If yes, are the limitations or impairments reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe.

Y N 1b. If yes, are the limitations or impairments reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? Please describe.

Y

2. Does your use of alcohol or chemical substances(s), including prescription medications, in any way impair or limit your ability to practice as an acupuncturist with reasonable skill and safety? Please describe.

Y

3. Are you engaged in any illegal use of controlled substances including use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider). Please describe.

Y N 3a. If yes, have you taken any steps (i.e. treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe.

Y N 3b. If yes, are you now participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe.

Y

4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice acupuncture with reasonable skill and safety? If you answer this question 'yes", please answer the following:

Y N 4a. With regard to any condition referenced above, are you being treated so that such impairment is avoided?

Y N 4b. With regard to any condition referenced above, are you in compliance with the recommended treatment?

Y N 4c. With regard to any condition referenced above, has your treating physician advised you that you are able to practice as an acupuncturist with reasonable skill and safety?

4d. Please explain._____

4e. Identify your treating physician._____

Y N

5. Have you ever been diagnosed as having or have you been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? Please describe.

Y N

6. Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars.

Y N	7. Have you ever been denied a registration/certification/licensure or the privilege of taking an acupuncture certifying examination or has a conditioned registration/certificate/license ever been issued to you by any state board or other licensing authority? If so, give particulars.
Y N	8. Has your license/registration/certificate to practice as an acupuncturist in any state or country ever been voluntarily or involuntarily (i.e. by State Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a State Board or other licensing authority? If so, give particulars.
Y N	9. Have you ever been notified of any investigations by any state board, acupuncture society, certifying authority or any health facility of any complaints against you relative to the practice as an acupuncturist, or have you been reprimanded or censured by any acupuncture society or licensing board? If so, give particulars.
Y N	10. Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, give a detailed clinical explanation of each case as well as documentation of outcome (insurance papers or court documents).
Y N	11. Have you ever been denied, restricted, or revoked staff affiliations with a hospital, nursing home, clinic, or other health care facility? If so, give particulars.
Y N	12. Have there been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, give particulars including the date of conduct, state and local jurisdiction in which the charges were filed.
Y N	13. Have there been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemicals filed against you? If so, give particulars, including the date of conduct, state and local jurisdiction in which the charges were filed.

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 and rule requirements for licensure. The information is classified as private while your application is pending or if your application is denied, and as public if your license 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 licensed by the Board.

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 am the person named in the diploma, which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, my references, personal physicians, employers (past and present), business and professional associates (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for registration 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 as an acupuncturist 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 by the Board.

Sworn to before me this _____ day of _____, _____. _____

Signature of Applicant

Signature of Notary Public _____

My Commission Expires: _____

Paste a recent photo, front-view passport-type photo in this square

CERTIFICATION OF IDENTIFICATION
Certification of Notary Public is required.

I certify that on the date set forth below, the individual named above did appear Personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. Sworn to before me by the applicant on this _____ day of _____ , _____.

Signature of Notary Public _____

Expiration Date _____ / _____ / _____

NOTARY SEAL

_____

Signature of Applicant

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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, discharged less than six months ago. Discharge date: _____

___ Yes, still in active military duty.

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 been convicted 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 felony or gross misdemeanor convictions on or after July, 1, 2013.

Applicant Name (printed): _____

Applicant Signature:_____ Date _____

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ACUPUNCTURIST
Verification of Licensure/Registration/Certification

This form is for verification of all acupuncturist and other health care professional licenses or registrations from every jurisdiction issuing any type of license, registration, or certification including training, and temporary permit even if license is not current. **Each Board completing this 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 jurisdiction completes the following information:

It is hereby certified that:_____
(Name of Applicant)

Date of birth: _____
(Month / Day / Year)

Was issued license/registration number: _____

By: _____ On:_____
(State) (Month / Day / Year)

Expiration date is: _____
(Month / Day / Year)

Issued on the basis of: _____

Disciplinary action ever initiated, pending, or invoked? Yes*_____ No_____

Ever voluntarily relinquished license? Yes*_____ No _____

State Seal**

Print name: _____

Signature: _____

Title: _____

Date: _____

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

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ACUPUNCTURIST
Recommendation Form

This form must be completed and mailed directly to the Minnesota Board of Medical Practice by two acupuncturists or other health care professionals who are knowledgeable regarding applicant's professional conduct and character and is not a family member. The applicant's signature authorizes release of the information, favorable or otherwise, directly to the Board.

Print Applicant Name: _____

Signature: _____ Date: _____

* *

The person serving as a reference completes the following information:

RECOMMENDATION FOR: _____
(Print name of Applicant)

1. How long have you known the applicant? _____

2. What has been the nature of your relationship with the applicant? _____

   _____

3. How would you characterize the moral and professional conduct of the applicant? _____

4. Would you recommend the applicant for approval of licensure for the practice of acupuncture?

   _____

   _____

5. Circle the word(s) which best describes this applicant:

   A. Clinical Skills: Marginal* Fully Meets Standards

   B. Any indication of chemical dependency? Yes* No
   *Please attach letter of explanation

* *

Completed By: Name (Please Print) _____

Signature _____ Date _____

Health Profession _____ License # _____ State _____

Phone _____ Fax _____ Email _____

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ACUPUNCTURIST
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This form must be completed and mailed directly to the Minnesota Board of Medical Practice by two acupuncturists or other health care professionals who are knowledgeable regarding applicant's professional conduct and character and is not a family member. The applicant's signature authorizes release of the information, favorable or otherwise, directly to the Board.

Print Applicant Name: _____

Signature: _____ Date: _____

* *

The person serving as a reference completes the following information:

RECOMMENDATION FOR: _____
(Print name of Applicant)

1. How long have you known the applicant? _____

2. What has been the nature of your relationship with the applicant? _____

   _____

3. How would you characterize the moral and professional conduct of the applicant? _____

4. Would you recommend the applicant for approval of licensure for the practice of acupuncture?

   _____

   _____

5. Circle the word(s) which best describes this applicant:

   A. Clinical Skills: Marginal* Fully Meets Standards

   B. Any indication of chemical dependency? Yes* No
   *Please attach letter of explanation

* *

Completed By: Name (Please Print) _____

Signature _____ Date _____

Health Profession _____ License # _____ State _____

Phone _____ Fax _____ Email _____

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Treating Physician Statement

Applicant: Applicants who have a medical condition during the last five years which, if untreated, would be likely to impair their ability to practice with reasonable skill and safety must have their treating physician complete this form. A treating physician is the physician who diagnosed and provides or provided treatment for the condition and includes the current treating physician.

Treating Physician: Complete and mail this form directly to the Minnesota Board of Medical Practice. This form is also available on our website.

Applicant's Printed Name_____

Applicant's Date of Birth (Mo/Day/Yr)_____ Health Profession_____

I hereby authorize you, my treating physician, to disclose my medical records to the Minnesota Board of Medical Practice. 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 oral information or documents, records, or other information to the Board.

Signed_____ Date_____

Nature of medical condition including diagnosis and significant symptoms

Date first saw patient: _____ **Date last saw patient:** _____

Has the applicant been compliant with treatment? (If no, please explain)
☐ Yes ☐ No

What medications is the applicant taking for this condition?

If this medical condition was untreated, would it be likely to impair the applicant's ability to practice with reasonable skill and safety? (If yes, please explain) ☐ Yes ☐ No

Should the condition be monitored? (If yes, please explain) ☐ Yes ☐ No

Treating Physician (print name)_____

Signature_____ Date_____

Phone_____ Fax_____