

Transfer Care Specialist Registration Renewal Application

MORTUARY SCIENCE

In accordance with [Minnesota Statutes, section 13.41 \(https://www.revisor.mn.gov/statutes/cite/13.41\)](https://www.revisor.mn.gov/statutes/cite/13.41), **all data submitted on this registration application shall be classified public information upon issuance of a registration.**

This application is for applying for renewal of your registration as a Transfer Care Specialist subject to the provisions of [Minnesota Session Laws 2024, chapter 127, article 18 \(https://www.revisor.mn.gov/laws/2024/0/Session+Law/Chapter/127/\)](https://www.revisor.mn.gov/laws/2024/0/Session+Law/Chapter/127/).

Instructions for Attachments

Applicants must submit the complete renewal application form and the following documents to the Minnesota Department of Health (MDH):

- Proof of completion of at least three hours of continuing education on content including the following:
 - Ethical care and transportation procedures for a deceased person.
 - Health and safety concerns to the public and the individual performing the transfer of the deceased person, and the use of universal precautions and other reasonable precautions to minimize the risk for transmitting communicable diseases.
 - All relevant state and federal laws and regulations related to the transfer and transportation of deceased persons.

Note that the seven hours of training required for your initial registration application will not count toward the three hours of annual continuing education required under [Minnesota Session Laws 2024, Regular Session, Chapter 127, Article 18, Section 7, Subdivision 4 \(b\) \(https://www.revisor.mn.gov/laws/2024/0/Session+Law/Chapter/127/\)](https://www.revisor.mn.gov/laws/2024/0/Session+Law/Chapter/127/).

Keep a copy of the application and attachments for your records.

Submission of Application Fee Payment

Applicants must upload the application and required attachments to the [MDH Facility and Provider Licensing System \(https://hrdlicensing.web.health.state.mn.us/\)](https://hrdlicensing.web.health.state.mn.us/).

All applications require a fee of \$226.00. You will receive a notice to submit payment once the application form and attachments have been received.

Transfer Care Specialist services may not be provided by the applicant until MDH issues the registration.

Applicant Information

Registration Number:

Last Name:

First Name:

Middle Name:

Date of Birth (dd/mm/yyyy):

Mailing Address:

City/State/Zip:

Telephone:

Email Address:

Have you ever used another name under which records may be filed concerning your application?

No

Yes

If yes, list name(s) used: _____

Employment Information

Name of Establishment: _____

Establishment License Number: _____

Mailing Address: _____

City/State/Zip: _____

Telephone: _____

Email Address: _____

Designated Address

Your designated address is where MDH will send correspondence about your registration. Once your registration is issued, this address will be public information. Select your designated address from the options below:

Applicant Mailing Address

Employer Mailing Address

Verification

- I understand pursuant to [Minnesota Statutes, section 13.04](https://www.revisor.mn.gov/statutes/cite/13.04) (<https://www.revisor.mn.gov/statutes/cite/13.04>) Rights of Subjects of Data, the commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets the requirements for approval of registration as a Transfer Care Specialist. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a registration.
- I understand in accordance with [Minnesota Statutes, section 144.051](https://www.revisor.mn.gov/statutes/cite/144.051) (<https://www.revisor.mn.gov/statutes/cite/144.051>) Data Relating to Licensed and Registered Persons, all data submitted on this application shall be classified as public information upon issuance of a registration. All data submitted are considered private until MDH makes a final determination regarding the application.
- I understand that information submitted to the Commissioner in this registration application may, in some circumstances, be disclosed to other persons or entities including the Minnesota Department of Health and its staff, staff of the Attorney General's office, and persons whom they contact including any person to whom the Commissioner must refer the application or parts thereof for verification purposes or determination of your qualifications, and to persons you designate.
- I understand if the registration application becomes contested and thereby results either in a contested-case hearing or litigation, the data submitted by you or on your behalf may also become accessible to the Minnesota Office of Administrative Hearings, appropriate courts, and those associated with such proceedings, and thereby become public data.
- I certify that the information provided on this form is true and correct to the best of my knowledge.
- I understand that providing false information may result in denial of this application.

I submit this application to practice as a Transfer Care Specialist subject to the provisions of [Minnesota Session Laws 2024, Regular Session, Chapter 127, Article 18](https://www.revisor.mn.gov/laws/2024/0/Session+Law/Chapter/127/) (<https://www.revisor.mn.gov/laws/2024/0/Session+Law/Chapter/127/>).

Printed Name of Applicant: _____

Signature of Applicant: _____

Date: _____

Transfer Care Specialist Supervisor Information

Supervising morticians are required to complete this form. Applications for Transfer Care Specialist registration without supervision information will not be processed.

Supervisor's Name: _____
Supervisor's License Number: _____
Supervisor's Telephone: _____
Supervisor's Email: _____
Establishment Name: _____
License Number: _____
Establishment Address: _____
City/State/Zip: _____
Telephone: _____

Acknowledgement

- I certify that I will be the licensed mortician to direct and supervise the applicant listed below for the duration of their employment at the establishment listed above.
- I acknowledge that I must provide Direct Supervision of the Transfer Care Specialist under my supervision. [Minnesota Session Laws 2024, Regular Session, Chapter 127, Article 18, Section 7, Subdivision 1 \(https://www.revisor.mn.gov/laws/2024/0/Session+Law/Chapter/127/\)](https://www.revisor.mn.gov/laws/2024/0/Session+Law/Chapter/127/)
- I acknowledge that I am responsible for the work performed by the Transfer Care Specialist(s) under my supervision.
- I acknowledge that I may supervise no more than four Transfer Care Specialists at any one time.
- I have read and understand the requirements of [Minnesota Session Laws 2024, Regular Session, Chapter 127, Article 18 \(https://www.revisor.mn.gov/laws/2024/0/Session+Law/Chapter/127/\)](https://www.revisor.mn.gov/laws/2024/0/Session+Law/Chapter/127/).

Printed Name of Applicant: _____

Signature of Supervising Mortician: _____

Date: _____

Minnesota Department of Health
Health Regulation Division
State Licensing, Certification, and Registration
PO Box 64882
St. Paul, MN 55164-0882
651-201-4200
health.mortsci@state.mn.us
www.health.state.mn.us

10/25/2024

To obtain this information in a different format, call: 651-201-4200.