DEPARTMENT OF HEALTH

Transfer Care Specialist
Change of Information – Employment and/or Supervisor

MORTUARY SCIENCE

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

Applicant Information

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 license. Once your license 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) 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 license.
- ☐ I understand in accordance with Minnesota Statutes, section 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 provisional license. 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 licensing 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 license 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/).

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 registered licensee 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/)

☐ 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/).

Printed Name of Applicant: _____

Signature of Supervising Mortician: _____

Date: _____

Minnesota Department of Health
Health Regulation Division
Attn: Mortuary Science
PO Box 64882
St. Paul, MN 55164-0882
651-201-4200
health.mortsci@state.mn.us
www.health.state.mn.us

04/08/2025

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