## DEPARTMENT OF HEALTH

## Minnesota Registration & Certification System (MR&C) Medical Certifier / Designated Staff User Agreement

Only physicians, advanced practice registered nurses, physician assistants, coroners, or medical examiners (medical certifiers) have legia autority to provide cause of death information in Minesota. Medical certifiers may: <ul> <li>Enter the cause of death information (CDD) to someone in their office to enter into MR&amp;C on their behalf. These "designated staff" must be MR&amp;C users. The medical certifiers may will print on the death certificate.</li> <li>Physician /Assistant</li> <li>Add</li> <li>Change</li> <li>ReQUIRED: License number</li> <li>License number</li> <li>REQUIRED: The medical certifier to (M.D., P.A., CN, P.O.S):</li> <li>Clinic/Office/Hospital Name</li> <li>Clinic/Office/Hospital Name</li> <li>Clinic/Office/Hospital Name</li> <li>Clinic/Office/Hospital Name</li> <li>Clinic/Office/Hospital Name</li> <li>Clinic/Office/Hospital Street address, city, state and ZIP**</li> <li>Have new AMR&amp;C user account</li> <li>Security email address</li> <li>Additional email address</li> <li>How heave and MR&amp;C user account</li> <li>Ves, want staff from my facility to enter COD information into MR&amp;C or me: Lunderstand that I must supply the COD</li> <li>Ves (to designated staff from my facility to enter COD information into MR&amp;C on my behalf.</li> <li>Iwill enter the COD into MR&amp;C my RAC user accounts</li> <li>Ves (to designated Staff</li> <li>Mol No (a not want to saign staff from my facility to enter COD information into MR&amp;C on my Back Cert</li> <li>Ves new cause and mannee of death information that the medical certifier named on the death record gives me.</li> <li>Undient the COD into MR&amp;C my RAC user accounts</li> <li>Onlo (a) ont want to saign staff from my facility to enter COD information into MR&amp;C on my Back Cert</li> <li>Ves new cause and mannee of death information that the medical certifier named on the death record g</li></ul>	Complete this form to become an authorized user of MR&C, the statewide electronic system for registering deaths in Minnesota.										
1. Enter the cause of death information (CDD) to someone in their office to enter into MR&C on their behalf. These "designated staff" must be MR&C users. The medical certifier's name will print on the death certificate.  Physician Advanced Practice Registered Murse/Physician Assistant Add Change Remove First name MI Last name REQUIRED: Title related to certifier role / Title Phone (10 digit related to certifier role Change									aminers ( <i>medical</i>	certifiers)	
2. Furnish cause of death information (CDD) to someone in their office to enter into MR&C on their behalf. These "designated staff" must be MR&C users. The medical cartifier's name will print on the death certificate.  Physician/Advanced Practice Registered Nurse/Physician Assistant  REQUIRED: Icleanse number  I lass name  REQUIRED: License number  REQUIRED: Title related to certifier role/ Title Phone (10 digit license number (M.D., P.A., CNP, CNS):  Clinic/Office/Hospital Name  Clinic/Office/Hospital street address, city, state and ZIP*  Physician MR&C user acount Physician MR&C user acount Physician MR&C user acount Physician MR&C user acount Physician State may password, and I will not tog into MR&C with another user's information.  If do not abide by this agreement, the Minnesota Department of Health may disable my MR&C user account.  Yes, I want staff from my facility to enter COD information into MR&C or my behalf.  No. I do not want to assign staff from my facility to enter COD information into MR&C or my behalf.  No. I do not want to assign staff from my facility to enter COD information into MR&C user account.  Physignature  Date signate Coptional) Designated Staff D address Additional email address Business phone (10 digit)  By signing this document 1 agree that: Additional email address Business phone (10 digit)  By signing this document 1 agree that: Additional email address Additional email address Additional email address Business phone (10 digit)  By signing this document 1 agree that: Additional email address Additional email address Business phone (10 digit)  By signing this document 1 agree that: Additional email address Business phone (10 digit)  By signing this document 1 agree that: Additional email address Business phone (10 digit)  By signing this document 1 agree t							cal certifie	rs may:			
staff" must be MR&C users. The medical certifier's name will print on the death certificate. Physician Advanced Practice Registered Murse/Physician Assistant REQUIRED: License number Hi License number REQUIRED: License number REQUIRED: Title related to certifier role / Title Phone (10 digit license number (M.O., P.A., CNP, CNS): Title Phone (10 digit license number (M.O., P.A., CNP, CNS): Additional email address If id on table by this agreement, the Minnesota Department of Health may disable my MR&C user account. If id on table by this agreement, the Minnesota Department of Health may disable my MR&C user account. If id on tables the certificate. No, I do not want to assign staff from my facility to enter COD information into MR&C or me. I understand that I must supply the COD to the designated staff, that these staff will use their own MR&C user accounts to enter the COD, and that my name will print on the death certificate. No, I do not want to assign staff from my facility to enter COD information into MR&C on my behalf. Signature Designated Staff fust name MI Designated Staff last name Designated Staff fust name D											
First name       MI       Last name       REQUIRED: NPI number         REQUIRED: License number related to certifier role       License number (N.O., P.A., CNP, CNS):       Title Phone (10 digit license number (N.O., P.A., CNP, CNS):         Clinic/Office/Hospital Name       Clinic/Office/Hospital street address, city, state and ZIP**         I have an MR&C user account       Security email address       Additional email address         I've never used MR&C before       Security email address       Additional email address         I've never used MR&C before       I will not share my password, and I will not log into MR&C with another user's information.         I've is ve static to easign at the time may assword, and I will not log into MR&C with another user's information.         I've is ve static to easign at the time my password, and I will not log into MR&C or me; understand that I must supply the COD to the designated staff, that these staff will use their own MR&C user accounts to enter the COD, and that my name will print on the death certificate.         I'vel new the COD Into MR&C myself.       Date signature         Signature       MI       Designated Staff flast name       Date signed         Optional) Designated Staff       Additional email address       Business phone (10 digit)         By signing this document I agree that:       Additional email address       Business phone (10 digit)         By signing this document I agree that:       I will not share my password, and I will not											
REQUIRED: License number       License number       REQUIRED: Title related to certifier role / Title       Phone (10 digit         Clinic/Office/Hospital Name       Clinic/Office/Hospital street address, city, state and ZIP**         I have an MR&C user account       Security email address       Additional email address         I'le newer used MR&C before       My signature on this document means that:       I'le newer used MR&C user account.         I'll do not abide by this agreement, the Minnesota Department of Health may disable my MR&C user accounts.       I'le not abide by this agreement, the Minnesota Department of Health my disable my MR&C user accounts.         I'll do not abide by this agreement, the Minnesota Department of Health my disable my MR&C user accounts.       I'le not abide by this agreement, the Minnesota Department of Health my disable my MR&C user accounts.         I'll do not abide by this agreement, the Minnesota Department of Health my disable my MR&C user accounts.       I'le not abide by this agreement, the Minnesota Department of Health my disable my MR&C user accounts.         I'll do not abide by this agreement, the Minnesota Department of Health my disable my MR&C user accounts.       I'le my MR&C user accounts.         I'll do not abide by this agreement, the Minnesota Department of the ath mere user's information.       I'le not abide by this agreement, the Minnesota Department of the ath mere user's information.         I'll do not abide by this agreement, the Minnesota Department of lealth may disable my MR&C user account.       Dete signet dignet         Designate											
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related to certifier role       licess number (M.D., P.A., CNP, CNS);         Clinic/Office/Hospital Name       Clinic/Office/Hospital street address, city, state and ZIP**         Clinic/Office/Hospital Name       Clinic/Office/Hospital street address, city, state and ZIP**         Clinic/Office/Hospital Name       Clinic/Office/Hospital street address, city, state and ZIP**         Clinic/Office/Hospital Name       Additional email address         My signature on this document means that:       Additional email address         I do not abide by this agreement, the Minnesota Department of Health may disable my MR&C user account.       I must staff from my facility to enter COD information into MR&C for me. I understand that I must supply the COD to the designated staff, that these staff will use their own MR&C user accounts to enter the COD, and that my name will print on the death certificate.         No       No, 1 do not want to assign staff from my facility to enter COD information into MR&C on my behalf.         Signature       Date         Designated Staff fust name       MI         Designated Staff first name       MI         Designated Staff fust name       Additional email address         Busings this document I agree that:       I will nee the cause and manner of death information that the medical certifier named on the death record gives me.         I will here that cause and manner of death information that the medical certifier named on the death record gives me.         I will here that cause a											
Clinic/Office/Hospital Name       Clinic/Office/Hospital street address, city, state and ZIP** <ul> <li>I have an MR&amp;C user account</li> <li>Security email address</li> <li>Additional email address</li> <li>I was staff from my facility to enter COD information into MR&amp;C user account.</li> <li>Ves, I want staff from my facility to enter COD information into MR&amp;C on my behalf.</li> <li>I will enter the COD into MR&amp;C myself.</li> </ul> <li>Signature         <ul> <li>Date signed</li> <li>Coptional Designated Staff</li> <li>Additional email address</li> <li>Business phone (10 digit)</li> </ul> </li> <li>By signing this document I agree that:         <ul> <li>I will enter the cause and manner of death information that the medical certifier named on the death record gives me.</li> <li>I understand that under Minnesota Statutes, there are penalities for unlawful use of data.</li> <li>I do not abide by this agreement, the Minnesota Department of Health may disable my MR&amp;C user account.</li> </ul> </li> <li>Designated Staff first name</li> <li>MI</li> <li>Designated Staff last name</li> <li>I will keep MR&amp;C secure. I will not share my password, and I will not log into MR&amp;C with another user's information.</li> <li>I will enter the cause and manner of death in</li>	-		Licens	se num	ber	-			Phone (10 d	git	
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I will enter the COD into MR&C myself.         Signature       Date         Signed       Optional) Designated Staff       Add       Change       Remove         Designated Staff first name       MI       Designated Staff last name       I am an MR&C user       I've never used MR&C before         Designated Staff business email address       Additional email address       Business phone (10 digit)         By signing this document I agree that:       -       -       -       -         I will keep MR&C scure.       I use have my password, and I will not log into MR&C with another user's information.       -       -       -         I will enter the cause and manner of death information that the medical certifier named on the death record gives me.       -       -       -       -         I will enter the cause and manner of death information that the medical certifier named on the death record gives me.       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -       -											
I will enter the COD into MR&C myself.         Signature       Date         Signature       Date         (Optional) Designated Staff       Add       Change       Remove         Designated Staff first name       MI       Designated Staff last name       I am an MR&C user         Designated Staff business email address       Additional email address       Business phone (10 digit)         By signing this document I agree that:       I will not share my password, and I will not log into MR&C with another user's information.         I will enter the cause and manner of death information that the medical certifier named on the death record gives me.       I understand that under Minnesota Statutes, there are penalties for unlawful use of data.         I I do not abide by this agreement, the Minnesota Department of Health may disable my MR&C user account.       Designated Staff         Designated Staff first name       MI       Designated Staff last name       Date         Designated Staff business email address       Additional email address       Business phone (10 digit)         By signing this document I agree that:       I am an MR&C user       I ve never used MR&C before         Designated Staff business email address       Additional email address       Business phone (10 digit)         By signing this document I agree that:       I will not log into MR&C with another user's information.       I will enter the cause and manner of death	□ No										
Isigned         (Optional) Designated Staff         Designated Staff first name       MI       Designated Staff last name       I am an MR&C user         Designated Staff business email address       Additional email address       Business phone (10 digit)         By signing this document I agree that:       •       I will not share my password, and I will not log into MR&C with another user's information.         • I will enter the cause and manner of death information that the medical certifier named on the death record gives me.       •         • I understand that under Minnesota Statutes, three are penalties for unlawful use of data.       •         • If I do not abide by this agreement, the Minnesota Department of Health may disable my MR&C user account.       Deate         Designated Staff first name       MI       Designated Staff last name       I am an MR&C user         I operated Staff business email address       Additional email address       Business phone (10 digit)         By signing this document I agree that:       •       I am an MR&C user       I am an MR&C user         • I will keep MR&C secure. I will not share my password, and I will not log into MR&C with another user's information.       •       •         By signing this document I agree that:       •       I will not log into MR&C with another user's information.       •         • I will keep MR&C secure. I will not share my password, and I will no	I will enter the COD into MR&C myself.										
(Optional) Designated Staff       Image: Change in Remove         Designated Staff first name       MI       Designated Staff last name       Image: Image											
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Authority: Minnesota Rules, chapter 4601.1800, Minnesota Statutes, section 144.213 subd.1 and, Minnesota Statutes, section 144.221, subd.2.