PAB
Physician Assistant Board

PHYSICIAN ASSISTANT TRAINING PROGRAM CERTIFICATION

Print or Type *(Read instructions before completing)*

(A): TO BE COMPLETED BY APPLICANT

1. Name	Last	First	Middle
2. Mailing Address	Number and Street (include apartment number, if applicable)		
	City	State	Zip Code
3. Telephone Numbers			
Home		Cell	

(B): TO BE COMPLETED BY PROGRAM

This certifies that _____ of _____, matriculated
NAME ADDRESS

in _____ and has attended this institution
NAME OF PA PROGRAM

from _____, _____, to _____, _____, successfully completing

the training for licensure as a Physician Assistant as set forth in the Physician Assistant regulations.

For a "Yes" response to ANY of the following questions, the training program should provide a brief written explanation on a separate attachment.

1. Did this individual ever take a leave of absence from their medical education? ☐ Yes ☐ No
2. Was this individual ever placed on probation? ☐ Yes ☐ No
3. Was this individual disciplined or under investigation? ☐ Yes ☐ No
4. Were there incident reports regarding this individual ever filed by instructors? ☐ Yes ☐ No
5. Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason? ☐ Yes ☐ No

CERTIFICATION

OFFICIAL SEAL

Signed and the school seal affixed this

_____ day of _____, _____

By _____

Title _____

After completion by the approved Program, this form must be mailed by the Program to the Board at the below address.

FAXES ARE NOT ACCEPTABLE.

PA6

08A-PA-07a (Rev 8/15)