PAB
Physician Assistant Board

VERIFICATION OF LICENSURE PHYSICIAN ASSISTANT OR OTHER HEALTHCARE PROFESSIONAL

Instructions to the Applicant: Please complete Part I below and forward a copy of this form to **ALL** states, territories, licensing or registration jurisdictions where you have **EVER** been licensed or registered, including any other health care professions. Copy this form as needed. Please type or print legibly.

PART I: TO BE COMPLETED BY APPLICANT

1. Name	Last	First	Middle
2. Other Names Used (Including Birth Name)		**3. Date of Birth**	MM/DD/YY
4. Mailing Address	Number and Street (include apartment number, if applicable)		
	City / State / Zip Code		
5. Applicant Signature		**5. Date of Signature**	

I hereby authorize your agency to release information concerning my licensure/registration/certification status. Please return this completed form to the Board at the address listed below. All questions must be answered.

PART II: TO BE COMPLETED BY STATE BOARD OR OTHER LICENSING JURISDICTION

Instructions to the Licensing Agency: Please complete Part II below for the applicant identified above and mail this document directly to the Physician Assistant Board. **Faxes are not acceptable.**

License Type	State	License Number	Issue Date	Expiration Date

If YES to any of the following questions, please provide any information and documentation which may be released, including charges and final disposition.

1. Have any complaints been filed against the license? ☐ Yes ☐ No ☐ Unable to answer
2. Is there any pending investigation regarding the license? ☐ Yes ☐ No ☐ Unable to answer
3. Has any disciplinary activity been taken regarding this license? ☐ Yes ☐ No ☐ Unable to answer

CERTIFICATION

OFFICIAL SEAL

Verified by _____
Signature

Print Name _____

Title _____

Date _____

Telephone Number _____

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2005 Evergreen Street, Suite 1100, Sacramento, CA 95815 (916) 561-8780 FAX: (916) 263-2671 www.pac.ca.gov