



PHYSICIAN ASSISTANT TRAINING PROGRAM CERTIFICATION



Instruction to the Applicant: Please Complete Part A and send this form by mail, email, or fax to your training program for completion.

PART A: TO BE COMPLETED BY APPLICANT

Name of Applicant	Telephone Number		
Number and Street	City	State	Zip Code

The person listed above has applied for a physician assistant license in California. Before further consideration is given to this application, the Physician Assistant Board would appreciate your assistance in completing the information requested below. Please mail the completed original form to the Board at the address listed below. **Faxed and emailed copies are not acceptable.**

PART B: TO BE COMPLETED BY PHYSICIAN ASSISTANT PROGRAM

This certifies that _____, matriculated in
STUDENT NAME
 _____ and has attended
NAME OF PA PROGRAM
 _____, from _____ to _____, successfully
NAME OF SCHOOL DATE DATE
 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, please supply a brief written explanation on a separate attachment.

1. Did this individual ever take an academic or disciplinary leave of absence? Yes No
2. Was this individual ever disciplined, under investigation, or placed on disciplinary probation? Yes No
3. Were there incident reports regarding this individual ever filed by instructors? Yes No
4. Were any limitations or special requirements imposed on this individual because of academic or disciplinary reasons? Yes No

CERTIFICATION

Signed and the school seal affixed this _____ day of _____, _____

OFFICIAL SEAL

Signature
Printed Name
Title of Authorized Official
Telephone Number

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