PAB Physician Assistant Board

PHYSICIAN ASSISTANT TRAINING PROGRAM CERTIFICATION

PART A: TO BE COMPLETED BY APPLICANT

Instructions to the Applicant: Please Complete Part A and send this form to your training program for completion.

1. Name	Last	First	Middle	**3. Telephone Number**	
2. Mailing Address	Number and Street	City		State	Zip Code

PART B: TO BE COMPLETED BY PHYSICIAN ASSISTANT PROGRAM

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

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 a leave of absence for disciplinary reasons?	Yes ☐ No ☐
2. Was this individual ever disciplined, under investigation, or placed on disciplinary probation?	Yes ☐ No ☐
3. Were any incident reports regarding this individual ever filed by instructors?	Yes ☐ No ☐
4. Were any limitations or special requirements imposed on this individual for disciplinary reasons?	Yes ☐ No ☐

CERTIFICATION

OFFICIAL SEAL

Signed and the school seal affixed this

_____ day of _____ , _____

_____
Signature

_____
Printed Name

_____
Title of Authorized Official

_____
Telephone Number

PA6

REV 06/2018