PAB Physician Assistant Board

VERIFICATION OF LICENSURE

Instruction to the Applicant: Please complete Part A 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 regardless of the status of those licenses or registrations. Copy this form as needed. Please type or print legibly.

PART A: TO BE COMPLETED BY APPLICANT

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

Type of License	License Number	Issue Date	Expiration Date

I hereby authorize your agency to release information concerning by licensure/registration/certification.

Signature Date

Instructions to the Licensing Agency: The person listed above has applied for a physician assistant license in California. Please complete Part B below and mail the completed form to the Board at the address listed below. **Faxes/emails are not acceptable.**

PART B: TO BE COMPLETED BY STATE LICENSING BOARD OR AGENCY

Licensee's Full Name			State of Issuance
Type of License Issued	License Number	Issue Date	Expiration Date

License Status (please check one box):

Active ☐ Inactive ☐ Other ☐ If other, please explain _____

Has this agency taken any disciplinary action against this license? Yes ☐ No ☐

If disciplinary action has been taken against this licensee, please provide all official public records directly to this office in regard to this action.

CERTIFICATION

OFFICIAL SEAL

_____
Signature

_____
Printed Name

_____
Title of Authorized Official

_____
Date

_____
Telephone Number

PA 7