PAB Physician Assistant Board

PHYSICIAN ASSISTANT BOARD
VERIFICATION OF LICENSURE

PART A: TO BE COMPLETED BY APPLICANT

Instructions to the Applicant: Please complete Part A and send this form to **ALL** states, territories, licensing or registration jurisdictions where you have **EVER** been licensed, certified, or registered, in any healthcare professions regardless of the status of those licenses, certifications, or registrations. Copy this form as needed. Please type or print legibly.

1. Name	Last	First		Middle
2. Other Names (Include Birth Name)		**3. Telephone Number**		
4. Mailing Address	Number and Street	City	State	Zip Code

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

Signature Date

PART B: TO BE COMPLETED BY LICENSING BOARD OR AGENCY

Instructions to the Licensing Agency: The person listed above has applied for a physician assistant license in California. Please complete Part B and **mail** the completed form to the Board at the address listed below. If disciplinary action has been taken against this licensee, please provide all official public records directly to the Board. **Faxed or emailed copies are not acceptable.**

Licensee's Full Name	State of Issuance

License Type	License Number	Issue Date	Expiration Date

License Status

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

CERTIFICATION

OFFICIAL SEAL

Signature

Printed Name

Title of Authorized Official

Date

Telephone Number

PA7

REV 06/2018