VERIFICATION OF PHYSICIAN ASSISTANT PROGRAM

TO BE COMPLETED BY THE APPLICANT:

Full Name of Applicant:

Address:

Social Security Number:	**Date of Birth:**

_____

Applicant's Signature

TO BE COMPLETED BY REGISTRAR OR PROGRAM DIRECTOR: Please complete and return form directly to: Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0063. Express Mail: 11341 W. Chinden Blvd. Bldg 4, Boise, ID 83714; Fax: (208) 334-3536.

PLEASE INCLUDE A COPY OF OFFICIAL TRANSCRIPTS

Degree Received:	**Date of Degree:**

As an official of the school named, I certify that the person named above received a degree as noted after fulfilling all requirements.

_____

Please type or print name of Registrar/Director

_____

Signature of Registrar/Director

(SEAL)

_____

Name of School or Facility

_____

If changed, present name

_____

City **State** **Zip**

_____

Date of this Verification