VERIFICATION OF EDUCATION

TO BE COMPLETED BY THE APPLICANT:

(For PA Certificate program graduates only - Not required for applicants with a baccalaureate or higher in PA Studies.)

Full Name of Applicant:

Address:

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

Applicant's Signature

TO BE COMPLETED BY REGISTRAR: 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

Major:	
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.

(SEAL)

Please type or print name of Registrar

Signature of Registrar

Name of School or Facility

If changed, present name

City **State** **Zip**

Date of this Certification