CANNON BUILDING
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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

Verification of Physician Assistant Education

Institution:_____	Applicant's Name:_____
Address:_____	Address:_____
City/State/Zip:_____ _____ _____	City/State/Zip:_____ _____ _____

This section is to be completed by applicant.

Be sure to sign the form.

Last Name:_____ First Name:_____

SSN:_____ DOB:_____

Name if Different from Above:_____

I am applying for licensure as a Physician Assistant in the State of Delaware. Before my application can be reviewed, verification of my Degree or Certification is required. I am authorizing the release of the information requested on this form.

Signature: _____ Date: _____

Program Participation to be completed by the Institution:

Our records indicate that _____ _____ _____ was enrolled in
(Type / print individual's name: Last, First, middle)
our institution during the following dates (mm/dd/yyyy):

From	To
_____/_____/_____	_____/_____/_____
Month Day Year	Month Day Year

This individual (check one):

☐ was awarded the degree of _____ on _____/_____/_____
Month Day Year

☐ was NOT awarded a degree (please attach an explanation)

Certification

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

*****AFFIX**

Name:_____ Signature:_____

OFFICIAL

Title:_____ Date of Signature: _____

SEAL HERE

Tel: _____ Fax: _____ E-mail: _____

*****RETURN COMPLETED FORM WITH SEAL AFFIXED TO THE BOARD ADDRESS ABOVE. THANK YOU.**