

Wisconsin Department of Safety and Professional Services

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MEDICAL EXAMINING BOARD

PHYSICIAN ASSISTANT CERTIFICATE OF PROFESSIONAL EDUCATION

APPLICANT - Please complete this section and submit to certifying school for completion. Form must be returned directly from the school to the Department at the above address.

Name

First Middle (Maiden) Last

Social Security Number*

____ - ____ - _____

Address

Street City State Zip

Date of Graduation

___ / ___ / ___

CERTIFYING SCHOOL - Please complete this section and return directly to the Department at the above address.

Name of Institution

Location of Institution

City State

Type of Degree Awarded

Major

Date Diploma Granted** ___ / ___ / _____

Signature of Dean or Department Head

Date ___ / ___ / _____

SCHOOL SEAL

* For school's use in locating your records.

** **COMPLETE THIS FORM AFTER THE APPLICANT NAMED ABOVE HAS ACTUALLY GRADUATED.** Anticipated dates of graduation will not be accepted.