

# Wisconsin Department of Safety and Professional Services

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## MEDICAL EXAMINING BOARD

### ANESTHESIOLOGIST ASSISTANT CERTIFICATE OF PROFESSIONAL EDUCATION

**APPLICANT - Please complete this section and forward 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: \_\_\_ / \_\_\_ / \_\_\_\_\_

**SEAL**

**SCHOOL**

\* For school's use locating your records.

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