

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
Fax #: (608) 251-3036
Phone #: (608) 266-2112

Ship To: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

MEDICAL EXAMINING BOARD

PHYSICIAN ASSISTANT CERTIFICATE OF PROFESSIONAL EDUCATION

APPLICANT: 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.

Last Name	First Name	MI	Former / Maiden Name(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Address: (street, city, state, zip)

Date of Birth:	Social Security #: (voluntary-for use by school to locate your records)
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>

I hereby authorize the school named below to provide the Department with the information requested below.

<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Applicant Signature (Print and Sign Form)	Date

SCHOOL: Certify completion after the applicant named above has actually graduated and return directly to DSPS: You may fax/email with facility cover sheet/letter to: (608) 251-3036 or dspscredmedbdaffiliates@wisconsin.gov.

Name of School:

Location of School: (city/state)

Type of Degree Awarded:

Major:

Date of Diploma Granted: / / (anticipated dates of graduation will not be accepted)

<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Signature (Print and Sign Form)	Date

SCHOOL SEAL