

# 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](mailto: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)

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

 /  / 

**Applicant Signature**

**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](mailto: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)

 /  / 

**Signature**

**Date**

**SCHOOL SEAL**