MEDICAL EXAMINING BOARD
REQUEST FOR NATIONAL EXAMINATION SCORES

APPLICANT: PLEASE COMPLETE THIS FORM AND FORWARD TO:

NATIONAL COMMISSION FOR CERTIFICATION OF ANESTHESIOLOGIST ASSISTANTS (NCCAA)
8459 US HWY 42, #60
FLORENCE, KY 41042
EMAIL: cynthia.m@nccaa.org
WEB SITE: www.nccaa.org

(Please print clearly)

NAME: ______________________________________________________
      (Last) (First) (Middle)

ADDRESS: ___________________________________________________
          (Street) (City) (State) (Zip)

SSN#: ___________________________ or Certificate # ___________________________

I authorize the National Commission on Certification of Anesthesiologist Assistants to release to the Wisconsin Medical Examining Board all of the information requested below. I recognize that it is my responsibility to apply for the next available NCCAA examination and failure to appear for this examination will result in termination of my temporary certificate.

_____________________________________________________________
APPLICANT’S SIGNATURE
DATE

ATTENTION: National Commission on Certification of Anesthesiologist Assistants

PLEASE MAIL THE INFORMATION BELOW TO THE FOLLOWING ADDRESS:

- Pass/Fail Status.
- Historical record of all examinations written, including scores and dates.
- National certifying certificate number and status of this certificate.

Department of Safety and Professional Services
Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935