

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: ____ / ____ / ____

SCHOOL SEAL

* 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.