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

Office Location: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

MEDICAL EXAMINING BOARD

ANESTHESIOLOGIST 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.

Last Name | **First Name** | **MI** | **Former / Maiden Name(s)**

Address (number/street) | (city) | (state) | (zip code)

Date of Birth __ __ / __ __ / __ __ __ __

Social Security Number (voluntary-for use by school to locate your records) ___-___-____

Date of Graduation (Anticipated dates of graduation will not be accepted.) __ __ / __ __ / __ __ __ __

Application Number

ATTESTATION OF APPLICANT: I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations.

Applicant Signature (If unable to provide a digital signature, please print and sign form.) | **Date** __ __ / __ __ / __ __ __ __

SCHOOL: Complete this section for the above-named applicant and return directly to the Department using the LicensE Third-Party* Upload Portal at license.wi.gov. You will need the application number shown above. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

Name of School

Location of School (City, State) | __ __

Type of Degree Awarded

Major

Date Diploma Granted __ __ / __ __ / __ __ __ __ (Anticipated dates of graduation will not be accepted.)

Continued on next page.

Wisconsin Department of Safety and Professional Services

ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT: I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.

Signature of Dean or Department Head
(If unable to provide a digital signature, please print and sign form.)

Date __/__/____

Printed Name

Phone ___-___-____ Ext_____

Title