Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
Phone Number: (608) 251-3036
LicensE Portal: https://license.wi.gov/
Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

PHYSICIAN ASSISTANT AFFILIATED CREDENTIALING 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.

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 Education Program Completion**
__/__/____	___-__-____	__/__/____

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 print and sign form.)	**Application Number**		**Date**
	PAR-		__/__/____

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 of Program Completion	__/__/____	(Anticipated dates of program completion will not be accepted.)

ACCREDITATION: (Check one box below.)

☐ A. The program was accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), or its successor, at the time of applicant program completion.

☐ B. The program was completed by the applicant **prior to 2001** and was accredited by the Committee on Allied Health Education and Accreditation (CAHEA) or the Commission on Accreditation of Allied Health Education Programs (CAAHEP) at that time.

☐ C. Program was not accredited as noted in A or B above at the time of applicant program completion. (Please provide an explanation below.)

Continued on next page.

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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	**Daytime Phone Number**
	☐☐☐-☐☐☐-☐☐☐☐
Title	