Complete verifications must be mailed directly from the verifying agency to:

Board *of* Medicine
Council on Physician Assistants
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-3253

Board *of* Medicine
Physician Assistant Program Verification Request

Applicant Name: _____ Date of Birth: _____
MM/DD/YYYY

Physician Assistant Program Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

The individual listed above has applied to the Florida Council on Physician Assistants for licensure as a physician assistant. A diploma was submitted as proof of having completed educational prerequisites for licensure in Florida. Please authenticate by completing the following. This form must include a signature and seal.

Type of Degree Awarded: ☐ Bachelor's ☐ Master's ☐ Other: _____

Degree Issued Date: _____
MM/DD/YYYY

Comments (if any): _____

_____

_____

_____

Verified by:

Name of Verifier: _____

Signature of Verifier: _____

Date: _____ Title of Verifier: _____
MM/DD/YYYY

[SEAL]