MINNESOTA
BOARD OF MEDICAL PRACTICE

335 Randolph Avenue, Suite 140
St. Paul, MN 55102
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medical.board@state.mn.us | mn.gov/boards/medical-practice

PHYSICIAN ASSISTANT
Verification of Physician Assistant Education

This form is for certification of physician assistant education and must be completed and **emailed or mailed by the facility directly to the Minnesota Board of Medical Practice**. Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name: ____ SS#:____________________

Signature:____ Date:_____________

Date of Degree(mo/day/yr)____________________ Degree Received________________ * * * *
* *

The School completes the following information:

It is hereby certified that:____
(Name of Applicant)

Matriculated in:____
(Name of School)

Program located at: ____
(City/State of School)

And received a diploma conferring:_________________________ On:______________
(Degree) (Mo/Day/Year

Program accredited by: (check one)
___ Commission on Allied Health Education and Accreditation (CAHEA), Commission on Accreditation of Allied Health Education Programs (CAAHEP), or a successor agency
___ Accreditation Review Committee on Education for the Physician Assistant (ARC-PA)
___ Other (explain)______________________

Any disciplinary action? Yes*______ No______
***Please** attach letter of explanation.
Any derogatory information on file? Yes*______ No______

President, Secretary Dean, Registrar

School Seal**

Print Name: ____________________________

Signature: ______________________________

Title: _________________________________

Date: _________________________________

Phone: ____________________ Fax________________

**If there is no seal, attach letter of explanation on letterhead. 4/22