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STATE OF DELAWARE
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VERIFICATION OF PHYSICIAN ASSISTANT EDUCATION

Instructions: If you are *not* using the FCVS service, send this form to *each* program from which you graduated. This form must be sent directly from the Physician Assistant Program.

Educational Institution:_____ Address: _____ City/State/Zip: _____	Applicant Name: _____ Home Address: _____ City/State/Zip: _____
This section is to be completed by applicant.	Last Name: _____ First: _____ Middle: _____ SSN: _____ Birth Date: _____ Other Name(s) Used: _____ I am applying for licensure as a Physician Assistant in the State of Delaware. Before my application can be reviewed, verification of my degree or certification is required. I am authorizing the release of the information requested on this form. **Applicant Signature:** _____ Date: _____
This section to be completed by Institution.	1. Enter the dates the applicant named above was enrolled in your institution: From (month/day/year): _____ To (month/day/year): _____ 2. Was the applicant awarded a degree? Yes ☐ No ☐ • If yes, enter: Degree Received: _____ Date Degree Conferred (month/day/year): _____ • If no, attach explanation of reason applicant did not receive a degree.
AFFIX INSTITUTION OR NOTARY SEAL HERE	**I certify that the information above is an accurate account of the applicant's records and is true and correct.** **Printed Name of Institution Official:** _____ **Signature of Official:** _____ **Date:** _____ **Title:**_____ **Phone:** _____ **Fax:** _____ **Email:**_____

FORM MUST BE SENT DIRECTLY FROM THE PHYSICIAN ASSISTANT PROGRAM.