

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	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
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-	<input type="text"/>

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-DSPP 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	<input type="text"/>	(Anticipated dates of program completion will not be accepted.)	
ACCREDITATION: (Check <u>one</u> box below.)			
<input type="checkbox"/> 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.			
<input type="checkbox"/> B. The program was completed by the applicant prior to 2001 <u>and</u> was accredited by the Committee on Allied Health Education and Accreditation (CAHEA) <u>or</u> the Commission on Accreditation of Allied Health Education Programs (CAAHEP) at that time.			
<input type="checkbox"/> C. Program was <u>not</u> accredited as noted in A or B above at the time of applicant program completion. (Please provide an explanation below.)			

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

Daytime Phone Number

- -

Title