

PA 1
Verification of PA
Education
Supplemental Form

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836
www.mbp.state.md.us

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Program accredited?
Y _____ N _____
Date verified _____

**VERIFICATION OF PROFESSIONAL EDUCATION FOR
PHYSICIAN ASSISTANT LICENSURE**

Part 1 **APPLICANT:** Complete Part 1 and send to the institution where you completed your Physician Assistant program.

Name: _____
Last name and generational indicator (Jr., Sr., II, III, etc.) First name Middle name Maiden Name

Date of Birth: ____/____/____ Social Security Number: ____-____-____
mm dd yyyy

Professional School of Graduation: _____

Attended from: _____ to _____

Date of Graduation: _____ Degree Received: _____
mm/yyyy

Applicant's Signature: _____ Date: _____

Part 2 **REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL:** Please complete this form and email it to: mdh.mbpcredentials@maryland.gov.

I hereby certify that the above-named individual graduated from this institution on: _____
Date of Graduation (mm/yyyy)

The individual graduated with a(n):

Associate's Degree Certificate Bachelor's Degree Master's Degree Other: _____
(specify)

in _____ Educational Program. The program was accredited by: _____
ARC-PA, CAAHEP, CAHEA, etc.

Printed Name of Authorized Official _____ Name of Institution _____

Title of Authorized Official _____ Telephone Number _____ Fax Number _____

Signature of Authorized Official _____ Date _____

**SEAL
OF THE
INSTITUTION**