PHYSICIAN ASSISTANT PROGRAM VERIFICATION FORM

To: (Physician Assistant program address)	From: **Department of Health** **Council on Physician Assistants** **4052 Bald Cypress Way** **Bin #C03** **Tallahassee, Florida 32399-3253**

The individual listed below has applied to the Florida Department of Health, Council on Physician Assistants for licensure as a physician assistant. A diploma from your school was submitted as proof of having completed educational prerequisites for licensure in Florida. Please authenticate by signature and seal that the following is true and correct to your records.

Name:	____________________________ First Middle Last

DOB:	/ /

Profession:	**Physician Assistant**	Degree issue date:	/ /

Comments (if any):____

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Verified by: (signature)

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Name: (please print)

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Title:

SEAL