PHYSICIAN ASSISTANT BOARD
VERIFICATION OF LICENSURE

PART A: TO BE COMPLETED BY APPLICANT

A verification must be provided to the Board for each health care related license, certificate or registration regardless of the status. The Verification of Licensure form is a courtesy form you can choose to use to request a verification; the Board accepts other agencies' verification forms. Please complete Part A before sending the form to ALL states, territories, licensing or registration jurisdictions which you are, or have been licensed, certified or otherwise registered. Please print legibly.

1. Name	Last	First	Middle	
2. Other Names/Aliases		**3. Telephone Number**		
4. Mailing Address	Number and Street	City	State	ZIP Code

I hereby authorize your agency to release information concerning my licensure/registration/certification status.

Signature	Date

PART B: TO BE COMPLETED BY LICENSING BOARD OR AGENCY

The person listed above has applied for a physician assistant license in California. Please complete Part B and and mail, or email, the form directly to the Board at the address listed below. If disciplinary action has been taken against this licensee, please provide all official public records directly to the Board. **Faxed copies are not acceptable.**

Name		State of Issuance	
License/Certification/Registration Type	License/Certificate/Registration Number	Issue Date	Expiration Date
License/Certificate/Registration Status			
Has this agency taken any disciplinary action against this license/certificate/registration?		Yes ☐	No ☐

CERTIFICATION

OFFICIAL SEAL

Signature

Printed Name

Title of Authorized Official

Date

Telephone Number