Registered Physician Assistant Form 2

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

CERTIFICATION OF PROFESSIONAL EDUCATION

APPLICANT INSTRUCTIONS

1. Complete Section I in ink. Enter your name as it appears on your Licensure Application (Form 1). Be sure to sign and date item 8.
2. Send this form to the institution(s) you attended for completion of Section II and the certification. Be sure to include any fee required by the institution. A separate Certification of Professional Education should be submitted for each professional educational program you attended.
3. This form must be signed by the registrar of the institution and **both pages** of this form must be returned directly in a sealed school envelope to the Office of the Professions at the address at the end of this form. Forms returned by the applicant will not be accepted.

Section I: Applicant Information

1 **Social Security Number** ☐☐☐-☐☐-☐☐☐☐
(Leave this blank if you do not have a U.S. Social Security Number)

2 **Birth Date** ☐☐ ☐☐ ☐☐
mo . day yr.

3 **Print Your Name Exactly As It Appears On Your Licensure Application (Form 1)**

Last
First
Middle

4 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1
Line 2
Line 3
City
State Zip Code
Country/ Province

5 Print name under which certificate or degree was awarded: _____

6 Professional school attended: _____

7 Title of certificate or degree: _____ Date awarded: _____ / _____ / _____
mo. day yr.

8 I request and give my permission to the institution listed in item 6 above to complete the information on this form and send any documentation requested, including that requested on this form (e.g. an official transcript), to the New York State Education Department.

Applicant's signature: _____ Date: _____ / _____ / _____
mo. day yr.

Section II: Certification Of Professional Education

INSTRUCTIONS TO INSTITUTION REGISTRAR:

1. Complete Part A or Part B to document the applicant's education.
2. Complete Part C (Certification) and return **both pages** of this form directly to the Office of the Professions at the address at the end of this form. Do not return this form to the applicant.

Part A –Programs Registered By New York State As Licensure Qualifying Or Accredited By The Accreditation Review Commission On Education For The Physician Assistant (ARC-PA) At The Time The Applicant Completed The Program.

To be completed only by those schools at which the applicant completed a physician assistant program registered by the New York State Education Department as licensure qualifying or accredited by the ARC-PA.

It is certified that _____:
(Name of applicant – See Section I, item 5)

☐ was awarded the credential of _____ on _____ / _____ / _____
(Title of credential) *mo.* *day* *yr.*

OR

☐ on _____ / _____ / _____ this institution determined that the above-named student met all requirements for the credential and the
mo. *day* *yr.*

institution has agreed to award the credential of _____.
(Title of credential)

Part B – All Other Programs.

An official transcript or marksheet giving courses completed by year and grades and a syllabus of the course of studies completed must be attached.

(1) Date of applicant's entrance, and either the applicant's date of completion of studies or withdrawal from the school:

Entrance date: _____ / _____ / _____ ☐ Completion date: _____ / _____ / _____ ☐ Withdrawal date: _____ / _____ / _____
mo. day yr. mo. day yr. mo. day yr.

(2) Did the student complete at least 32 semester hours of classroom work? ☐ Yes ☐ No If "No", number of clock hours: _____

(2) Did the student complete 1,600 clock hours of supervised clinical training? ☐ Yes ☐ No If "No", number of clock hours: _____

(3) Credential Awarded: _____

(4) Date credential awarded: _____ / _____ / _____
mo. day yr.

Name of accrediting body or official organization that recognizes this program: _____

Address of accrediting body or organization that recognizes the program: _____

_____

Part C - Certification:

I hereby certify that to the best of my knowledge and belief the information in Section II is a true statement of the educational record of the individual named on this form.

Signature of Registrar _____ Date _____ / _____ / _____
mo. *day* *yr.*

Type or print name _____

Title or official position _____

Institution _____

Address _____

(INSTITUTION SEAL)

_____

Telephone number _____ Fax _____

E-mail _____

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Physician Assistant Unit, 89 Washington Avenue, Albany, NY 12234-1000.