WASHINGTON Medical Commission
Licensing. Accountability. Leadership.

PA

Washington Medical Commission
PO Box 47866
Olympia, WA 98504-7866
360-236-2750

Physician Assistant Training Program Director Verification and Evaluation of Training

To be completed by the applicant:

Facility name _____

Address _____

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification and evaluation of the training performed in your institution is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown above. **All questions must be answered.**

Applicant Name (Print)	Birth date (mm/dd/yyyy)
Signature of applicant	

To be completed by the facility/agency/program:

1. _____ is or was engaged in training in our
   Applicant Name (Print)

   program_____

   from beginning date (month and year) _____to ending date (month and year) _____

2. At the time this individual completed the physician assistant program, was the program accredited through the Committee on Allied health Education and Accreditation (CAHEA), the Commission on Accreditation of Allied Health Education Programs (CAAHEP), or the Accreditation Review Committee of Education for the Physician Assistant (ARC-PA? ☐ Yes ☐ No

   If yes, what year the initial accreditation granted? _____

3. Was the participant ever placed on probation, restricted, suspended, terminated or requested to voluntarily resign his/her participation in the program? ☐ Yes ☐ No

   If yes, please explain_____

Return to address listed above.

(SEAL)

Signature _____

Title _____

Address _____

City, State, Zip Code _____

Date_____ Phone (enter 10 digit #) _____