

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.