

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.