



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.					
Ap	olicant Name (Print)			Birth date (mm/dd/yyyy)	
Signature of applicant					
1.	be completed by the facility/agency/program: Applicant Name (Print) program is or was engaged in training in out				
	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?				
	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			
		City, State, Zip Code			
				r 10 digit #)	