

14. Academic Degrees

List all colleges and/or universities you attended **other** than your physician assistant program in chronological order.

- If you completed a combination program (e.g. BS/PA) check here. Report this information on the following page, "Physician Assistant Education". Make sure to report any **other** academic education on this page.

You may photocopy this page to report more than four (4) institutions, if necessary.

If a break of six (6) months or more occurred during the attendance dates you provide, report the beginning and ending dates on a separate 8.5" x 11" sheet of paper. It is not necessary to report breaks between institutions.

Name of Institution #1

Address

City State

Country ZIP/Postal Code

From To
 Month Year Month Year

Degree: B.A. B.S. None
 M.A. M.S.
 Other: _____

Name of Institution #2

Address

City State

Country ZIP/Postal Code

From To
 Month Year Month Year

Degree: B.A. B.S. None
 M.A. M.S.
 Other: _____

Name of Institution #3

Address

City State

Country ZIP/Postal Code

From To
 Month Year Month Year

Degree: B.A. B.S. None
 M.A. M.S.
 Other: _____

Name of Institution #4

Address

City State

Country ZIP/Postal Code

From To
 Month Year Month Year

Degree: B.A. B.S. None
 M.A. M.S.
 Other: _____

**17. Examination/
Certification
History**

Provide the most recent examination date and total number of attempts for each examination you have taken for purposes of **state licensure**.

Documentation:
You must include a notarized, legible photocopy of your NCCPA certificate.

Examination	Most Recent Attempt		No. of Attempts	Pass/Fail	
	Month	Year		P	F
PANCE	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PANRE	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
NCCPA Certification Date:	Month <input type="text"/>	Year <input type="text"/>			

**18. Recipient
Designation**

You must designate each professional licensing board, hospital or other credentialing entity where you want your Profile sent.

Addresses are not required for state medical boards.

If you wish to send your profile to more than 10 entities at the same time, discounts may apply. Please call FCVS for more information.

You may indicate additional commercial recipients on a 8.5" x 11" sheet of paper.

- I am undecided about where my Profile should be sent (See "Undecided Applicants" on page 4 of the instructions).
- I wish to forward my Profile to the following state licensing authority(ies):

- | | |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

- I wish to forward my profile to the following commercial entity or hospital:

<input type="text"/>

Complete Name of Recipient (Do not abbreviate)

<input type="text"/>

Contact (Individual to whom your Profile will be addressed)

<input type="text"/>

Address Line 1

<input type="text"/>

Address Line 2

<input type="text"/>

City

<input type="text"/>

<input type="text"/>

State/Province

Country (U.S. or Canada only)

<input type="text"/>

ZIP/Postal Code

<input type="text"/>

Telephone Number

<input type="text"/>

19. Fee Calculation

To avoid processing delays, please refer to page 3 of the FCVS instructions (Fees).

If you are uncertain about any aspect of fee calculation, call 1-888- ASK-FCVS for assistance.

Refunds for overpayment will be initiated at the time your Profile is completed.

IMPORTANT:

Other fee charges may not be included in this calculation for which you will be billed. Please see page 3 of the instructions for additional information.

Method of payment Check Money Order

Check/Money Order #: _____

Name on Check _____

A. Application Fee Please select one option (includes forwarding one (1) Physician Assistant Information Profile).

Check here if submitting this application 90 or more days from completion of your physician assistant program. 1 4 5 . 0 0

OR

Check here if submitting this application within 90 days from completion of your physician assistant program (a 20 percent discount applies). 1 1 5 . 0 0

B. Fee to forward additional Physician Assistant Information Profile(s) □, □□□□ . □□
 _____ Profiles x **\$35.00 each**

C. Shipping and handling (if applicable) □□ . □□
 Passport - **\$15.00**

TOTAL FEE SUBMITTED: \$ □, □□□□ . □□

20. Required Documents

Please use this checklist to be certain you have submitted all required documents. Some may not apply.

- | | |
|--|---|
| <input type="checkbox"/> Certified Birth Certificate | <input type="checkbox"/> Affidavit and Release from Applicant Form |
| - or - | |
| <input type="checkbox"/> Original Passport (with explanation) | <input type="checkbox"/> Authorization and Release of Information, Documents and Records Form |
| <input type="checkbox"/> Sent with application | |
| <input type="checkbox"/> Sent separate from application | <input type="checkbox"/> Notarized photocopy of NCCPA Certificate and/or recertification card |
| <input type="checkbox"/> Documentation (or explanation) of use of Alternate Name | <input type="checkbox"/> NCCPA Examination History Release |
| <input type="checkbox"/> 8.5" x 11" Photocopy of Physician Assistant Diploma | |

21. Signature

IMPORTANT:

Failure to complete this section will suspend all processing of your application.

I, the undersigned, hereby certify that I have read the "Instructions for Completing the FCVS Application" and agree to the terms and conditions set forth therein. Furthermore, I acknowledge that I have answered all questions and reported all information in this application truthfully and completely .

 Signature Date

**Affidavit and Release
and Authorization for Release of Information,
Documents and Records**

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the "Instructions for Completing the FCVS Application" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I waive confidentiality, authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service (FCVS) any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, my examination grades, or any other pertinent data and to permit FCVS or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application that can subsequently be provided to professional licensing boards, hospitals and other entities when I apply for licensure, staff membership, employment or other privileges.

I hereby release, discharge and exonerate FCVS, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by FCVS.

I will immediately notify FCVS in writing of any changes to the answers to any questions contained in this application if such a change occurs at any time prior to my FCVS Physician Information Profile being mailed.

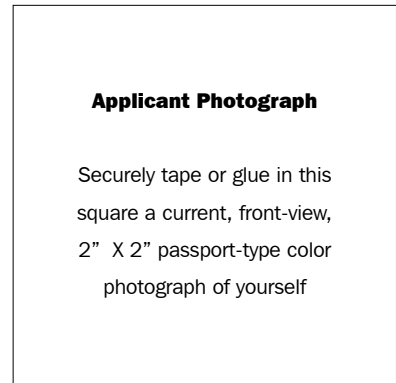
Applicant's Signature (must be signed in the presence of a notary)

Applicant's Printed Last Name

Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

_____ Date of Signature _____ Date of Birth

Applicant SSN



NOTARY

Your seal or stamp must be partly upon the photograph.

State of _____ County of _____

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 20 _____

My commission expires: _____

(NOTARY PUBLIC SIGNATURE & SEAL)

Notary Public signature: _____

I certify that on the date set forth above the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

National Commission on Certification of Physician Assistant
Request and Authorization
for Release of Information

Please type or print. Duplicate as needed

Section 1: Physician Assistant Identification

Name

Address

City State ZIP Code

Daytime telephone number: () - Last 4 digits of your SS #: _____

Section 2: Exam Information

Indicate for which exam and examination period you are requesting information. (Only one request per form)

- PANCE (Physician Assistant National Certifying Exam)
- PANRE (Physician Assistant National Recertifying Exam)
- Surgery Exam

Year: _____ Spring Fall

Section 3: Information Request

Indicate the nature of this request and the person or agency to whom it should be sent.

- Eligibility letter, verifying that you are eligible for and registered to take the above exam
- Pending letter, verifying that you have taken the above exam and are awaiting scores
- Exam results

Please send the above results to:

**Federation of State Medical Boards of the United States, Inc.
Federation Credentials Verification Service
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039-3855**

Section 4: Signature and Authorization

I authorize the NCCPA to release all information to the agency listed above.

Signature

Date