WYOMING BOARD OF MEDICINE

VERIFICATION OF PHYSICIAN ASSISTANT EDUCATION

I, ______________________________ , hereby authorize

______________________________ to furnish to the Wyoming Board of Medicine
Name of School

the required information necessary for licensure in the State of Wyoming.

Signature		Social Security Number
Type or Print Full Name		Current Address
Date		City, State, Zip

Physican Assistant School:

Please provide a statement below addressing periods of study and date diploma or certification was awarded. Faxes will not be accepted.

Signature		Name of School
Title		Address
Date		City, State, Zip
☐ Check here if no seal is available		Telephone

Affix Seal
Here

Please return this completed form to
Wyoming Board of Medicine
130 Hobbs Avenue, Suite A
Cheyenne, WY 82002