WYOMING BOARD OF MEDICINE

PHYSICIAN ASSISTANT LICENSE VERIFICATION REQUEST FORM

I_____, hereby authorize the State Board of

_____ to furnish to the Wyoming Board of Medicine the required information necessary for licensure as a physician assistant in Wyoming.

_____ _____ _____
Signature License Number Social Security Number

_____
Address City, State Zip Code

This section to be completed by State Medical/Physician Assistant Licensing Board

FULE NAME OF LICENSEE:_____

LICENSE NUMBER:_____ ISSUE DATE_____

EXPIRATION DATE:_____ STATUS:_____

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES_____ NO_____

Have formal disciplinary proceedings been initiated against applicant or applicant's license by a licensing or disciplinary authority in your state? YES_____NO_____

Has the applicant ever been warned, censured or in any other manner disciplined or has the applicant's license ever been revoked, suspended or in any other manner limited by a licensing or disciplinary authority in your state? YES_____NO_____

IF YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH CERTIFIED COPIES OF ORDERS.

SIGNATURE_____TITLE_____

NAME OF BOARD_____DATE_____

SEAL

Please Return To:
Wyoming Board of Medicine
130 Hobbs Avenue, Suite A
Cheyenne, WY 82002