FORM A
EDUCATION VERIFICATION FORM

Forward this form directly to your Respiratory Therapy Program for completion.

Applicant's Name: _____

Matriculation Date: _____ **(Beginning date of program)**
month/day/year

Type of Program (select only one):

□ Bachelor's Degree
□ Bachelor's Degree with Associate Equivalency Degree

This individual will/has complete(d) the program on: _____
month/day/year

Type of Program (select only one):

□ Associate's Degree
□ Certificate

This individual will/has complete(d) the program on: _____
month/day/year

Program Director/Registrar's Name: _____
Please print

Program Director/Registrar's Signature: _____

School Name: _____

City & State of School: _____

Today's Date: _____
month/day/year

School Seal

Please forward this form directly to:
Georgia Composite Medical Board
Respiratory Care Professionals Unit
2 Peachtree Street, N.W. – 36th Floor
Atlanta, GA 30303