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
□ Associate's Degree
□ Certificate

This individual **has completed** 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

Please forward this form directly to:
Georgia Composite Medical Board
Respiratory Care Professional Unit
2 Martin Luther King Jr. Drive, SE
East Tower, 11th Floor
Atlanta, GA 30334

Or

Email a PDF with visible School Seal to
GCMB.RespiratoryCare@dch.ga.gov

School Seal