FORM K
CERTIFICATE OF EDUCATION FOR PHYSICIAN ASSISTANT

It is hereby certified that _____
(student's Name)

of _____ **matriculated in** _____
(City, State of Birth)

at _____ **on** _____.
(beginning date of program)

The dates of attendance are certified to be: from _____ **to**

_____. **The above named applicant completed PA/AA**

studies from _____ **on** _____**and was**

granted a _____ **degree or certificate (please circle one).**

_____
Signature of Dean, Registrar or Director (please circle one)

(SCHOOL SEAL)

_____
Date Signed

_____
Notary Public

Sworn to and subscribed before me

This _____ **day of** _____, **20**_____ .

My commission expires _____ , **20**_____ .

Special Note: This form must be either notarized or have the school seal embossed or attached. Please email the completed form to:

medbd@dch.ga.gov