Verification of Graduation from
Physician Assistant Program

This section to be completed by the applicant.

Please complete this form, attach a picture of yourself and mail to the school from which you received your degree as a physician assistant. This completed form must be received by the South Dakota Board of Medical and Osteopathic Examiners before a South Dakota license is issued.

To: Dean, Physician Assistant School or Program

_____
_____
_____

The South Dakota State Board of Medical and Osteopathic Examiners requires that all applicants for licensure must provide verification of graduation from an approved physician assistant program and identification of a picture before a license can be issued. Please complete this form and mail it to the following address:

South Dakota Board of Medical & Osteopathic Examiners
125 South-Main-Avenue
Sioux Falls, South Dakota 57104

Applicant's Name _____
Address: _____
_____

(PICTURE)

Year of Graduation: _____

This section to be completed by the School of Graduation and returned directly to the South Dakota State Board of Medical and Osteopathic Examiners at the above address.

Name of School _____

Address of School _____
_____

Name of Graduate: _____

Year of Graduation: _____

I hereby certify the attached picture is a likeness of _____
and he/she graduated from _____
on _____

(SEAL)

Signed: _____
Title: _____
Date: _____