



# NCCPA Certification Verification and Exam History

## PA Licensure

Revised 10/2017

**INSTRUCTIONS TO APPLICANT:** Complete UPPER portion of form and send directly to the National Commission on Certification of Physician Assistants (NCCPA). NCCPA is to complete LOWER portion of the form and return **DIRECTLY** to the OREGON MEDICAL BOARD.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
Other Names you have been known by \_\_\_\_\_ Date of Birth (mm/dd/yy) \_\_\_\_\_ Last 4 Digits of Social Security Number \_\_\_\_\_

I authorize the release of any information, favorable or otherwise regarding myself to the Oregon Medical Board. By signing this document, I release the program and its representatives of liability for providing information to the Board.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Send form to: **National Commission on Certification of Physician Assistants**  
**12000 Findley Road, Suite 100**  
**Johns Creek, GA 30097** Phone: (678) 417-8100  
www.nccpa.net

**INSTRUCTIONS TO NCCPA:** Please complete this form, sign and return it to the Board at the address below in an institution envelope. **Faxed responses will NOT be accepted.**

National Certificate Number: \_\_\_\_\_  
Original Issue Date: \_\_\_\_\_ Previous Certificate Number (if applicable): \_\_\_\_\_  
Remains Valid Until: \_\_\_\_\_ Previous Certificate Expired Date: \_\_\_\_\_  
Current Status: \_\_\_\_\_

Number of times NCCPA exam taken: \_\_\_\_\_ Number of times failed NCCPA exam: \_\_\_\_\_

Exam Attempts				
Date	Exam Type	Score	Minimum Passing Score	Pass/Fail

Comments:

Signature of Official \_\_\_\_\_  
Print Name \_\_\_\_\_ Date \_\_\_\_\_  
Title \_\_\_\_\_  
Phone Number \_\_\_\_\_  
E-mail \_\_\_\_\_

Affix Seal Here