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VERIFICATION OF GOVERNMENT AGENCY PRIVILEGE TO PRACTICE

I verify that the following Board Certified physician assistant has current, unrestricted privileges to practice as a physician assistant for the government agency named below:

Name of Physician Assistant: _____

NCCPA ID #: _____

Expiration Date: _____

Agency/Facility Name: _____

Address: _____

Phone/Fax: _____

I can be reached by NCCPA via the following for additional information or follow up:

Printed Name: _____ Email: _____

Signature: _____ Date: _____