



VERIFICATION OF GOVERNMENT AGENCY PRIVILEGE TO PRACTICE

Please provide verification of the status of the following certified physician assistant's privileges to practice by **completing the following form in its entirety and returning the completed form to NCCPA** via fax or mail.

(The fax number and address are provided at the bottom of this form.) You may also scan the completed form and return it to NCCPA via email to specialtycaq@nccpa.net.

Name of Physician Assistant _____

NCCPA ID #: _____

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

Government Agency/Facility Name: _____

Expiration Date: _____

Printed Name of Verifier: _____

Title: _____

Address: _____

Phone: _____

Fax: _____ Email: _____

Signature of Verifier: _____ Date: _____