



**Atlanta Veteran Affairs Medical Center
Physician Assistant Post-Graduate Residency Program**

APPLICANT INFORMATION

Name (Last, First):

Date:	Date of birth:	SSN:
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Phone:	Gender: Male Female (Circle)	E-mail:
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Current address:

City:	State:	ZIP Code:
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Have you ever worked for the Veterans Administration before? YES NO

Are you a citizen of the United States? YES NO

Are you authorized to work in the U.S.? YES NO

Have you ever been convicted of a felony? YES NO

If yes, explain:

EDUCATION INFORMATION

High School:

Address:

City:	State:	ZIP Code:
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From:	To:	Date of Graduation:
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College:

Address:

City:	State:	ZIP Code:
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From:	To:	Date of Graduation:	Degree:
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Physician Assistant Program:

Address:

City:	State:	ZIP Code:
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From:	To:	Date of Graduation:	Degree:
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NCCPA number:	Expected PANCE date:
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Graduate Training (School Name):

Address:

City:	State:	ZIP Code:
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From:	To:	Date of Graduation:	Degree:
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REFERENCES

List three professional references. Each should submit a letter of support for your application
(One letter must be from your Program Director)

1. Full Name:

Relationship:	Company:	Phone:
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Address:

City:	State:	ZIP Code:
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2. Full Name:

Relationship:	Company:	Phone:
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Address:

City:	State:	ZIP Code:
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3. Full Name:		
Relationship:	Company:	Phone:
Address:		
City:	State:	ZIP Code:
Personal Statement		
I certify that information in this application is complete and correct to the best of my knowledge.		
Signature of applicant		Date

Please return application to:

**Atlanta VAHCS Physician Assistant Post-Graduate Residency Program in Primary Care
Office of PA Residency Director
Education Service Line
1670 Clairmont Road, Decatur, GA 30033
Mail Stop Code-VLC141
Attn.: Shelia H. Palmer, PA-C, MBA, MHA**