



**Atlanta Veteran Affairs Healthcare System  
Physician Assistant Post-Graduate Residency Program**

**APPLICANT INFORMATION**

Name (Last, First):

Date:

Date of birth:

Phone:

Gender: Male Female (Circle)

E-mail:

Current address:

City:

State:

ZIP Code:

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:

From:

To:

Date of Graduation:

Degree:

**College:**

Address:

City:

State:

ZIP Code:

From:

To:

Date of Graduation:

Degree:

**Physician Assistant Program:**

Address:

City:

State:

ZIP Code:

From:

To:

Date of Graduation:

Degree:

NCCPA number:

**Expected PANCE date:**

**Graduate Training (School Name):**

Address:

City:

State:

ZIP Code:

From:

To:

Date of Graduation:

Degree:

**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:

Address:

City:

State:

ZIP Code:

**2. Full Name:**

Relationship:

Company:

Phone:

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.**

<b>Signature of applicant:</b>	<b>Date:</b>
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**Please return the completed application and supporting documents by email:**

**Attn: Shelia H. Palmer, PA-C, MBA, MHA  
Shelia.palmer@va.gov**