U.S. Department of Veterans Affairs
Veterans Health Administration

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.		
Signature of applicant:		**Date:**

<u>Please return the completed application and supporting documents by email:</u>

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