Pennsylvania State Board of Medicine
2525 N. 7th Street, Suite 330
Harrisburg, PA 17110

Pennsylvania State Board of Medicine
P O Box 2649
Harrisburg PA 17105-2649

BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

VERIFICATION OF OPIOID EDUCATION

SECTION 1 – TO BE COMPLETED BY APPLICANT/LICENSEE

NAME:	Last	First	Middle
OTHER NAME(S):			
DATE OF BIRTH:		**LAST 4 DIGITS OF SSN:**	
LICENSE NUMBER:			
ADDRESS:			
CITY / STATE / ZIP:			

The following information must be completed by the educational program and must verify that you have successfully completed at least 2 hours of education in pain management or the identification of addiction and 2 hours of education in the practices of prescribing or dispensing of opioids.

SECTION 2 – TO BE COMPLETED BY DEAN OR REGISTRAR OF MEDICAL SCHOOL, PHYSICIAN ASSISTANT PROGRAM, OR NURSE-MIDWIFE ADVANCED PHARMACOLOGY PROGRAM, OR BY THE PROGRAM DIRECTOR OF AN AOA OR ACGME-ACCREDITED TRAINING PROGRAM

NAME OF SCHOOL/PROGRAM:	
ADDRESS:	
CITY / STATE / ZIP:	

I hereby certify that the above-listed individual successfully completed 2 hours of education in pain management or the identification of addiction and 2 hours of education in the practices of prescribing or dispensing of opioids on

_____/_____/_____.

Month Day Year

I verify that the above statements are true and correct as validated by my review of the applicant's records. I verify that the information communicated on this form is true and correct to the best of my knowledge, information and belief. I understand that any false statement made is subject to the penalties of 18 PA. C.S. §4904, relating to unsworn falsification to authorities.

SIGNATURE OF DEAN/REGISTRAR/ PROGRAM DIRECTOR:	
DATE:	

Upon completion, school must return this completed form directly to the Pennsylvania State Board of Medicine.

RETURN THIS FORM TO:
PENNSYLVANIA STATE BOARD OF MEDICINE
P O BOX 2649
HARRISBURG PA 17105-2649