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**WASHINGTON ACADEMY OF PHYSICIAN ASSISTANTS**

Scholarship Grant Application

**FACULTY REFERENCE**

Applicant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby certify that the above applicant is enrolled at our school as stated in this application and is in good academic standing.

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Program Director or Academic Advisor Date

Comments:

Program Director or Academic Advisor: Please mail this form directly to:

WAPA Scholarship Committee

2001 Sixth Ave. Ste. 2700

Seattle, WA 98121

Fax: (206) 441-5863