FIU | Herbert Wertheim College of Medicine
FLORIDA INTERNATIONAL UNIVERSITY

# PHYSICIAN ASSISTANT PROGRAM – SHADOWING FORM

USE ONE VERIFICATION FORM FOR EACH SHADOWING/VOLUNTEER EXPERIENCE

| TO BE COMPLETED BY THE APPLICANT<br><br>Falsification of any part of this document will result in the removal of the applicant for admission consideration and if admitted, immediate dismissal from the program. | |
|---|---|
| **Applicant's Full Name:** | **Applicants' Email:** |
| **Applicant's Current Address:** | **Applicant's Current Phone Number:** |
| **Type of Setting/Clinical Site:** | |
| **Dates of Experience:** | |
| **Please describe your shadowing or volunteer experience, including the types of services provided and specific tasks you observed. If you require more space, feel free to include a separate attachment.** | |
| **Total Hours Claimed:** | **Signature of Applicant:** |

| TO BE COMPLETED BY THE HEALTHCARE PROVIDER/VERIFYING OFFICIAL<br><br>Your signature is verification that the applicant observed a healthcare provider (PA, NP, MD, or DO) in practice or participated in a volunteer direct patient care experience. | |
|---|---|
| **Name of Healthcare Provider/Verifying Official:** | **Title of Healthcare Provider/Verifying Official:** |
| **Phone Number:** | **Email Address:** |
| **Signature:** | **Date:** |
| **Comments:** | |