

PHYSICIAN ASSISTANT PROGRAM – SHADOWING FORM

USE ONE VERIFICATION FORM FOR EACH SHADOWING/VOLUNTEER EXPERIENCE

TO BE COMPLETED BY THE APPLICANT

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

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:	