



MOUNT ST. JOSEPH UNIVERSITY
Physician Assistant Program

Direct Patient Care Verification Form

Instructions: Please complete this form to verify that you have participated in 500 hours of direct patient care experiences, which may be paid or voluntary.

To be completed by Applicant:

Applicant: Last Name:	First Name:	Middle Name:
Date of Birth:	Phone Number:	Email:

Direct Patient Care Experience:

Supervisor Name: _____

Employer/ Facility Name: _____

Type of Practice: _____

Job Title/ Type of experience: _____

Date(s) of Experience(s): _____

Total Number of Hours: _____ (500 hours is the minimum requirement)

Describe your Direct Patient Care experience, types of patients seen, and duties performed:

Applicant's Signature: _____

Date: _____

To be completed by Supervisor:

I verify that _____ has had direct patient care experience as indicated above.

Signature _____ Date _____

Name (print) _____

Address _____

Email: _____ Phone Number _____

Thank you for making a contribution to the application process for future physician assistants.

Contact: www.msj.edu 5701 Delhi Rd, Cincinnati, OH 45233. 513-244-4310. PAProgram@msj.edu