**Physician Assistant Shadowing Verification Form**

Instructions: Please complete this form to verify that you have participated in a shadowing experience with a practicing physician assistant. **The program requires 40 hours of shadowing.**

**To be completed by Applicant:**

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

**Shadowing Experience:**

Physician Assistant Name: \_\_

Employer/Name of Institution: \_\_

Type of Practice/ Specialty: \_\_

Date(s) Shadowed: \_\_

Total Number of In-Person Shadowing of Hours:

Describe your PA shadowing experience, types of patients seen, patient-related activities & duties of the PA:

Applicant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**To be completed by Physician Assistant:**

I verify that shadowed me as indicated above.

*(Name of Applicant)*

Signature , PA-C Date

Name (printed) , PA-C

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: NCCPA ID:

Are you interested in being a preceptor for MSJ’s PA Program? Yes No

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

**Contact us: 513-244-4310.** [**PAProgram@msj.edu**](mailto:PAProgram@msj.edu)