Physician Assistant Shadowing Verification Form

Instructions

Please complete this form to verify that you have participated in an experience with a practicing physician assistant. This experience should be in the form of shadowing, or internship.

Applicant Information

Name_____

Current Address_____

City_____ State_____ Zip _____

Shadowing Experience

Institution/ Location_____

Dates of Experience_____

Total Number of Hours_____

Physician Assistant Information

Name_____

Workplace_____

Address_____

City_____ State_____ Zip_____

Phone_____ Email _____

I verify that the above named applicant participated in an opportunity to explore the physician assistant profession by spending time observing me in practice.

_____ _____

Physician Assistant Signature Date