Physician Assistant

Shadowing Verification

APPLICANT

I understand that 50 hours of direct shadowing of a clinically practicing physician assistant is required.

Applicant Name: _____
LAST NAME FIRST NAME

List the types of observations (use additional space if necessary):

SHADOWING VERIFICATION

Physician Assistant: Thank you for your willingness to assist this applicant in his/her required shadowing experience for the purpose of applying to our Physician Assistant Program.

The applicant named above completed _____ hours of observation in our facility on _____
DATE

Facility Name: _____

Comments (optional):

SIGNATURE

Physician Assistant

Printed Name: _____ Signature: _____

Telephone: (____)_____ Email: _____

Graduate Admission
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ursuline.edu/PA