FranklinPierce UNIVERSITY

# Physician Assistant Shadowing Verification

College of Graduate & Professional Studies

## Instructions

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

## Applicant Information

Name: _____ _____ _____
(First) (Middle Initial) (Last)

Current Address: _____

City: _____ State: _____ Zip: _____

## Shadowing Experience

Institution/Location: _____

Date(s) of Experience: _____

Total Number of Hours: _____

## Physician Assistant Information

Name: _____

Workplace_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

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

4/2014