Pfeiffer UNIVERSITY
Master of Science
Physician Assistant Studies

Direct Patient Care Experience/Shadowing Verification Form

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

Applicant Information

Name:	
Address:	
City:	
State:	
Zip Code:	

Experience Type

☐ Patient Care Experience
☐ Healthcare Experience
☐ Shadowing
☐ Volunteer

Clinic/Institution Information

Name:	
Address:	
City:	
State:	
Zip Code:	
Country:	
Dates of Experience:	
Total Number of Hours:	

Supervisor Information

Name:	
Title:	
Contact Phone:	
Contact Email:	

Please provide a brief description of the type of experience and responsibilities preformed.

I verify that the above named applicant participated in an opportunity to experience following a physician assistant or medical professional in my practice.

_____ _____
Physician Assistant or Medical Professional Signature Date