MOUNT ST. JOSEPH
UNIVERSITY
Physician Assistant Program

DIRECT PATIENT CARE VERIFICATION FORM

To be completed by Applicant:

Applicant Last Name _____ First Name _____

Address _____

Phone _____ Email _____

Supervisor Name _____

Employer _____

Type of Practice _____

Date(s) of Experience _____

Total Number of Hours _____ (500 hours is the minimum requirement)

Describe your Direct Patient Care experience, types of patients seen, and duties performed:

To be completed by Supervisor:

I verify that _____ has had direct patient care experience as indicated above.

Signature _____ Date _____

Name (print) _____

Address _____

Email _____

Phone Number _____