MOUNT ST. JOSEPH
UNIVERSITY
Physician Assistant Program

PA SHADOWING VERIFICATION FORM

To be completed by Applicant:

Applicant Last Name _____ First Name_____

Address _____

Phone _____ Email _____

Physician Assistant Name _____

Employer _____

Type of Practice _____

Date(s) Shadowed _____

Total Number of Hours (40 hours is the minimum requirement) _____

Describe your PA shadowing experience, types of patients seen, and the duties of the PA:

To be completed by Physician Assistant:

I verify that _____ shadowed me as indicated above.
(Name of Applicant)

Signature _____, PA-C Date _____

Name (printed) _____, PA-C

NCCPA ID _____

Please check if interested:

Yes, I am interested in being a preceptor for a MSJU PA student; contact me by

Phone: _____ Email: _____