Master of Medical Science
Physician Associate Studies
PA Shadowing Verification Form

Please complete this form to verify you have participated in a shadowing experience with a practicing physician assistant/associate. The program requires ***20 hours*** *of shadowing in a clinical setting.*

Applicant Full Name:____

Date of Birth:_________________________ Phone Number:____________________________

Email:____

Shadowing Experience

PA Name:____

Employer/Facility Name:____

Type of Practice (specialty) :____

Date(s) of shadowing:____

Total Number of Shadowing Hours: _________ (minimum of 20 hours required in person)

Please check if this experience was: ____ In Person ____ Virtual

Please describe your PA Shadowing experience below.

Applicant's Signature: ____Date: ____________

To be completed by the Physician Assistant/Associate:

I verify that____________________________(*student*) has shadowed me as indicated above.

Print Name: __________________________________ NCCPA ID:_____________________

Signature:____Date:______________________

Email__________________________________ Phone Number:_______________________

Are you interested in becoming a preceptor for Miami University's PA Program? Yes or No

Thank you for contributing to the application process for future PAs.
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