MIAMI UNIVERSITY

Master of Medical Science
Physician Associate Studies
Patient Care Hours Verification

*Please complete this form to verify that you have participated in **400 hours of patient care experiences** which may be paid or voluntary. Note the program highly recommends that candidates have direct patient care hours, for further details visit the FAQ page on our website.*

Applicant Full Name: _____

Date of Birth: _____ Phone Number: _____

Email: _____

Patient Care Experience

Supervisor Name: _____

Employer/Facility Name: _____

Type of Practice (specialty): _____

Date(s) of experience: _____

Total Number of Hours: _____ (a minimum of 400 in person hours required)

Please describe your experience below. Include the types of patients seen, duties performed, etc.

Applicant's Signature: _____ Date: _____

To be completed by the Supervisor:

I verify that _____ *(student)* has had patient care experience as indicated above.

Print Name: _____

Signature: _____ Date: _____

Address: _____

Email: _____ Phone Number: _____

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

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