MIAMI UNIVERSITY

Master of Medical Science
Physician Associate Studies
Patient Care Hours Verification

*Please complete this form to verify that you have participated in **200 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 (speciality):_____

Date(s) of experience:_____

Total Number of Hours:_____ (minimum of 200 hours is 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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