Physician Assistant Direct Health Care Experience Verification Form

Instructions

The program places importance on health care familiarity and evaluates the quality and quantity of an applicant’s experience with direct patient health care. Shadowing experience, although highly valued, does not count toward the total number of hours. Health care experience will be evaluated on the type of experience and the number of hours performed. Examples include (but aren’t limited to) the following. Volunteering at marathons, blood donor clinics, fundraising for medical causes, after-school programs, coaching, church reader, meals-on-wheels, research technician, lab-based researcher, unit secretary, ward clerk, peer educator, reader or other non-medical work in waiting room or other medical setting, medical lab technician, medical technologist, athletic trainer, audiologist, exercise physiologist, radiology technician, phlebotomist, optometry technician, registered dietician, patient care assistant, PT assistant, medical scribe, medical assistant, PT, RT, OT, MSW, EMT, LPN, chiropractor, RN, CNA, nurse’s aide, medic or corpsman, paramedic, OD, and foreign medical graduate.

Note: When volunteering, it is important that you are able to observe or participate in direct patient care.

A letter on official office stationary from each employer or volunteer office must be submitted with this form. This letter should outline the dates of occurrence, total hours worked and the type of duties performed.

Applicant Information

Name__________________________________________________________

Current Address_____________________________________________________________________________________

City__________________________ State______________ Zip________________________

Direct Patient Care Experience

Institution_________________________________________________________________________________________

Location___________________________________________________________________________________________

Phone Number_______________________________________________________________________________________

Dates of Experience_________________________________________________________________________________

Total Number of Hours__________________________________________________________

January 4, 2013
Health Care Experience Verification

Direct Patient Care Experience

Institution_______________________________________________________________

Location_________________________________________________________________

Phone Number________________________________________________________________

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Location_________________________________________________________________

Phone Number________________________________________________________________

Dates of Experience________________________________________________________

Total Number of Hours______________________________________________________

Signature of Applicant_____________________________________________________

Date_______________________________________________________________

Printed Name____________________________________________________________