PHYSICIAN ASSISTANT PROGRAM

Submit by uploading completed form to the documents section of CASPA
(Note: Upload all completed shadowing forms in one file.)

PA Shadowing Form

Applicant Name: _____
Social Security Number: _____
Address: _____
_____
Home Phone: _____ **Cell Phone:** _____

Physician Assistant Name: _____
Physician Assistant Phone: _____
NCCPA Certification Number: _____
Type of Practice: _____
Date Shadowed: _____
Number of Hours: _____

I verify that the above named applicant shadowed me for the listed number of hours.

Signature: _____ **Date:** _____

To the PA–

Please check below if interested (Ohio location only):

☐ **Yes, I am interested in being a preceptor for a Mount Union PA student; contact me by:**

Phone: _____ **or Email:** _____

To the Applicant –

Please describe your shadowing experience, taking care to emphasize the role of the physician assistant in the clinical environment using the space provided below: