Miami Dade College
Physician Assistant Program

The MDC PA program trains students for employment as medical professionals who diagnose illness, develop and manage treatment plans, prescribe medications, and often serve as patient's principal healthcare provider. Practicing Physician Assistants utilize a team approach in collaboration with physician partners and other members of the health care team.

The MDC PA program provides high quality education and training opportunities in primary care for students from diverse cultural backgrounds interested in providing health care services to the medically under-served residents in urban and rural communities, especially in Florida. It promotes and maintains high academic and professional standards. Through their tenure in the program, students participate in professional activities and continuing education to promote life-long learning. Graduates from the program are prepared with a level of didactic and clinical competence that provides successful entry into the profession.

The PA program is fully accredited (status-continued) by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) until September 2025. Graduates from the MDC PA program are eligible to take the Physician Assistant National Certification Exam (PANCE).

PHYSICIAN ASSISTANT PROGRAM APPLICATION PACKET INSTRUCTIONS

_____   _____
Student Name (Print)   **MDC Student Number**

The information in this application packet <u>must</u> be completed to be considered an applicant for the Physician Assistant program at Miami Dade College. It is the applicant's responsibility to <u>provide all necessary documentation</u> for each of the required content areas. Please be sure to follow the instructions provided to ensure the submission of a complete application packet.

Step 1: Apply to Miami Dade College – Applicants who have not enrolled in a credit class at MDC in the last 12 months, must apply to MDC for admission or readmission. (MDC student number is required)

- *Important for New/Current Student: Miami Dade College Student ID Number* - Miami Dade College's **online application** makes it quick and easy to apply. After you complete the online application at : https://sisvsr.mdc.edu/admission/ssncaveat.aspx?type=N
- Submit your high school and college and/or university transcript to:
  Miami Dade College
  Attention: Transcript Processing Services,
  11011 SW 104th Street, Room R301
  Miami, FL 33176-3393.

Step 2: Application to MDC Physician Assistant Program

<u>General Information:</u>

•Obtain knowledge about the PA profession: Becoming knowledgeable about the profession you are pursuing is important to help you in your career decision. An excellent place to begin learning about the profession is the American Academy of Physician Assistants' website at http://www.aapa.org and the Florida Academy of Physician Assistants www.fapaonline.org

•If you don't have previous medical experience, at least 50 hours of clinical and/or shadowing experience is highly recommended. This needs to be completed prior to **October 15th** of the year in which you are applying. Please utilize the Shadowing Experience form on pg. 14 of this application packet.

•All application documents must be received no later than October 15th of the year in which you are applying. Applications will not be accepted if ANY documentation is lacking. Do not turn in applications to the PA program directly, all applications must be submitted to the New Student Center in person or by mail no later than **October 15th.**

<u>Minimum Requirements:</u>

• Baccalaureate degree
• Minimum cumulative GPA for PA applicants is 3.0 and the minimum natural science GPA is 3.0
• Successful completion of HSC 0003 – Introduction to Health Care/Lab must be completed prior to the application deadline of **October 15th**. If applying for exemption please follow steps on website under step 3 at the bottom. https://www.mdc.edu/physicianassistant/admission-requirements.aspx
• PA-CAT taken and scores received by MDC PA program no later than October 15th.

*Please note that meeting the program's minimum requirements does not guarantee an admission test, interview, or admission to the program.

Submit or mail application with all required documents to:
Miami Dade College Medical Campus
New Student Center
950 N.W. 20th Street, Room 1113
Miami, FL 33127

PHYSICIAN ASSISTANT APPLICATION CHECKLIST

Completed PA Application Checklist is required to accompany each Application Packet.
Applications will not be accepted after October 15th of the year in which you are applying.

_____   _____
Student Name (Print)   **MDC Student Number**

	REQUIRED ITEMS/INFORMATION
1	**Complete the Miami Dade College Application** https://sisvsr.mdc.edu/admission/ssncaveat.aspx?type=N ▪ Applicants who have not enrolled in a credit class at MDC in the last 12 months, must apply to MDC for admission and pay a $30 admission fee. If you have taken classes at MDC previously but haven't taken a class in the last 12 months, you must reapply to MDC but the admission fee is waived. ▪ Applicants need a Miami Dade College Student ID Number prior to applying to MDC PA Program
2	**Program Application Transaction Record** ▪ Complete the MDC PA Program Application ▪ Submit payment of the $25 application fee at the Bursar's Office at the Medical Campus
3	**Miami Dade College Physician Assistant Application**
4	**Ensure completion of program admission requirements & Submission of PA-CAT score report. (See PA-CAT information sheet below)** Each applicant must also **submit official transcripts** to the MDC Transcript Processing Services. • The College requires 4-6 weeks to process domestic transcripts. Please plan accordingly. • Applicants are required to submit transcripts from all institutions attended. • Applicants are required to disclose information about previous admission to other professional programs. Failure to submit complete transcripts may result in forfeiting your application or dismissal from the PA program after admission.
5	**Health Care Experience Form & Verification Letter**
6	**Letter of Intent and Resume or Curriculum Vitae (CV)**
7	**Certification/Registration/Licensure Form** Each applicant must **submit copies of certification/registration/licensure**
8	**Reference List Form** Three recommendation letters are required, at least two from a healthcare provider (MD, DO, PA-C, ARNP). Letters must be on letterhead, and must be included as part of the application package. **DO NOT FAX, E-MAIL, OR SEND VIA THE U.S. MAIL.**
9	**Shadowing Experience Form** **For applicants who do not have previous healthcare experience,** 50 hours of clinical and/or shadowing experience is highly recommended. This needs to be completed prior to **October 15th** of the year in which you are applying.

_____   _____
Name of person receiving application (print)   **Date received**

Physician Assistant College Admissions Exam (PA- CAT) Information Sheet

The PA-CAT is now the official entrance exam to the MDC PA program. Please follow the following steps below and do your part to become familiar with the test, it's process, and associated deadlines.

Step 1. Go to https://www.pa-cat.com/ to register, pay, and schedule date for the PA-CAT.

- Ensure Miami Dade College is selected as the institution to receive your score report.
- Official PA-CAT score report must be received by the MDC PA program directly from the test sponsor no later than **October 15th**. It can take up to 6 weeks for scores to be sent. To avoid late arrival of your scores, the recommended last day to take the PA-CAT is September 15th. Score reports not received on time will not be accepted for the current application cycle.

Step 2. Study for the PA-CAT with resources provided on their website: www.PA-CAT.com

PA-CAT Study materials provided by Exam Master include:

- 120 Question PA-CAT Practice Exam
- Eight 50-Question Subject Exams
- Candidate PA-CAT Study Guide

PA-CAT Covered Subjects:

- Anatomy
- Physiology
- General Biology
- Biochemistry
- General and Organic Chemistry
- Microbiology
- Behavioral Sciences
- Genetics
- Statistics

The PA-CAT will be used in conjunction with your application and academic standing to determine ranking. Candidates with the highest rankings will be invited for an Oral interview. Good luck!

Miami Dade College
Medical Center Campus

APPLICATION FOR PROGRAM SELECTION

A one-time $25.00 application fee is required for each **associate degree** (AS and AAS) program application submitted. All nursing options are considered one program. Payment must be made to the Bursar's Office before the application can be processed.

Last Name (Print)	First	Middle

Student Number	Email address	

Address	Apt#	City	State	Zip

Telephone Number: _____

Day phone	Evening Phone	Alternate phone

PREVIOUS EDUCATION: LIST ALL INSTITUTIONS WITH DATES OF ATTENDANCE
(Official Transcripts must be evaluated by the College's transcript evaluator)

Vocational School, College, University (Attach list if more than two)

School Name	City	State	Zip	Attendance Dates From Mo/Yr to Mo/Yr	Degrees or # of credits earned & major

Vocational School, College, University (Attach list if more than two)

School Name	City	State	Country	Attendance Dates From Mo/Yr to Mo/Yr	Degrees or # of credits earned & major

PROGRAM FOR WHICH YOU ARE APPLYING: _____

(See Reverse Side)

TERM FOR WHICH YOU ARE APPLYING: ____ Fall (Aug-Dec) ____ Spring (Jan-Apr) ____ Summer (May-Jul) Year: ____

Nursing Students Only: ____ Full time ____ Part time ____ Bridge ____ Accelerated ____ Generic

____ Medical Center Campus or ____ Homestead Campus

Bridge Program Only: ____ On-Line ____ Face to Face

Do you hold a current license/certification in a health care field? ____ Yes ____ No ____

If so, in what field is it? _____

Note: Clinical participation in some programs require students to be at least 18 years of age. All students are subject to a criminal background check. Please consult the program web page (www.mdc.edu/medical) for further information.

An applicant who has been convicted of a felony or the subject of arrest pertaining to a controlled substance should confer with an authorized representative of the regulatory/licensing agency to determine eligibility for future credentialing and practice. Graduates are subject to the laws, policies, and procedures of their respective regulatory/licensing board. The college cannot assure licensure/certification. Students are subject to the policies and procedures of affiliating agencies.

I certify all statements given in this application are true and accurate and to the best of my knowledge. I agree to abide by the rules and regulations of Miami Dade College as published.

Applicant Signature	Date of Submission

Revised 4/2011

MIAMI DADE COLLEGE MEDICAL CAMPUS
Program Application Transaction Record (to be completed and signed by applicant)

A one-time non-refundable fee of $25 is required for each A.S. degree program to which the applicant is seeking admission. Applications will not be considered until this fee is paid in full.
To make this payment, please visit the MDC- Medical Campus Bursar's office located in the 1st building, 2nd floor, Room 1203.

_____   _____
Student Name (Print)   MDC Student Number

_____
Address

_____   _____
Phone Number   Date

A $25 application fee is being paid for the following program(s):

_____   BAS with Physician Assistant Studies Option
_____   Bachelor's Degree in Nursing N-5100
_____   Dental Hygiene-23022
_____   Diagnostic Medical Sonography-23039
_____   Health Information Management-23053
_____   Healthcare Informatics - 63014
_____   Histologic Technology-23063
_____   Medical Laboratory Technology-23023
_____   Nuclear Medicine- (AS Degree)-23069
_____   Nursing (all options)-23030
_____   Opticianry-23040
_____   Physical Therapy Assistant-23035
_____   **Health Science-23080**
_____   Radiography-A3036
_____   Respiratory Therapy-23045
_____   Veterinary Technology-23062

_____ **TOTAL DUE**   **AMOUNT PAID:** _____
                                                          DATE PAID: _____
ACCOUNT #1009000-D19000-90-40503   **RECEIPT #:** _____

_____   _____
Applicant's signature   **Cashier's signature**

Note: Cashier must enter pre-select program code number in the first five characters of the description field of the miscellaneous receipt.

MIAMI DADE COLLEGE
PHYSICIAN ASSISTANT APPLICATION

_____   _____
Student Name (Print)   **MDC Student Number**

_____   _____
MDC Student E-Mail   **Personal E-Mail**

Please answer all questions.

I. PERSONAL INFORMATION *(Type or neatly print)*

Name: _____   _____   _____
       Last   First   M.I.

If transcripts, test scores, or other documents are under another name, give name:
_____

Date of Birth _____/_____/_____   Social Security Number: _____/_____/_____

ADDRESS

_____
Number and Street   Apartment Number

_____
City   State   Zip   Country

_____
Home Phone   Cell Phone   Alternate Phone

II. CAMPUS RESEARCH DATA

Please provide the following ethnic-race, gender and citizenship data which are required by Federal agencies. Miami Dade College is open to all regardless of sex, race, color, national origin, or handicap.

Please Mark as Follows:

1. **Ethnic-Race Origin** - ☐Non-Hispanic White ☐Non-Hispanic Black ☐☐Hispanic White

   ☐Hispanic Black ☐American Indian or Alaskan Native ☐Asian or Pacific Islander

   ☐Black or African American ☐Other (Specify) _____

2. **Gender** - ☐Female ☐Male

3. **Citizenship** - ☐United States Citizen ☐Resident Alien ☐Refugee

4. **Native Language** - ☐English ☐Spanish ☐French ☐Creole

   ☐ Other (Specify) _____

5. **Veterans Preference** - If you are claiming Veterans preference please check the box and submit a copy of your DD form 214. ☐

6. **How did you learn about the MDC PA program?**

_____
_____

III. PROGRAM INTENTIONS AND MIAMI DADE COLLEGE ENROLLMENT STATUS

Program for which you are applying: ___*Health Science Program – 23080*_____

Please circle your Miami Dade College enrollment status:

1. New Student (have not completed any courses at Miami Dade)

2. Continuing Student (enrolled at Miami Dade during the last 12-month period)

3. Former Student (have taken courses at Miami Dade but have not enrolled at Miami Dade during the last 12-month period.)

4. Other _____

Have you previously been enrolled in a health care related program at Miami Dade College or another institution?

1. ☐No   2. ☐Yes   If yes, specify program and institution: _____
_____

IV. PREVIOUS EDUCATION: List all institutions with dates of attendance

High School (*You must have official high school transcripts sent to Miami Dade College Admission office.*)

_____

School Name	City	State	Zip Code	Date Graduated or will Graduate (Mo./Yr.)

College, Universities: (Attach list if attended more than two*)

_____

School Name	City	State	Attendant Date From (Mo./Yr.) To (Mo./Yr.)	Degrees or Number of Credits earned

_____

School Name	City	State	Attendant Date From (Mo./Yr.) To (Mo./Yr.)	Degrees or Number of Credits earned

V. Are you currently employed in the health care field?
Explain_____
_____
_____
_____
_____

VI. CONDUCT

Have you ever been convicted of anything other than a traffic violation?
☐No
☐Yes

If yes, please explain: _____
_____
_____
_____

Have you ever been arrested and charged with a felony pertaining to controlled substances to which you entered a plea of nolo contenders, or for which you were adjudicated or adjudication was withheld because of placement in a pre-trial intervention program?
☐No
☐Yes

If yes, please explain: _____
_____
_____
_____

VII. STATEMENT OF CERTIFICATION

I certify all statements given in this application are true and accurate to the best of my knowledge. I agree to abide by the rules and regulations of Miami Dade College as published. I also understand that the application and supporting documents are *valid for two (2) years*, that the application fee may not be waived nor is it refundable, and that the application and supporting documents become the property of Miami Dade College and cannot be returned.

_____   _____
Signature of Applicant   **Date of Application**

Program Admission Requirements

I have submitted an application, application fee and have requested that my transcripts be sent to MDC Kendall Campus, Transcript Evaluation Department. The following courses will transfer and meet the requirements of the Health Science Program. This will be reviewed by a transcript evaluator.

_____   _____

Student Name (Print)   **MDC Student Number**

RECORD OF PREREQUISITE COURSES

MDC Course Requirement	College/ University	Year	Equivalent Course	Equivalent Course Title	Grade
Math and Natural Science Courses					
General Chemistry I and Qualitative Analysis					
General Chemistry I and Qualitative Analysis Lab					
General Chemistry II and Qualitative Analysis					
General Chemistry II and Qualitative Analysis Lab					
Anatomy and Physiology 1					
Anatomy and Physiology 1 Lab					
Anatomy and Physiology 2					
Anatomy and Physiology 2 Lab					
Microbiology					
Microbiology Lab					
College Algebra (Or Higher) *					
Statistical Methods (Must take) *					
Program Specific					
Introduction to Health Care					
Introduction to Health Care Lab					

Highest Degree: _____   University/College: _____

* Baccalaureate degree or higher required & must include 2 levels of Math

NOTE:

- *All science lecture courses taken more than ten years ago must be repeated.*

- *In order to graduate from the program, students will be required to complete the foreign language competency requirement.*

HEALTH CARE EXPERIENCE FORM

_____   _____
Student Name (Print)   **MDC Student Number**

List all health care experience, both paid and/or volunteer, beginning with your present position. (Please insert additional sheet(s) if needed.) **PLEASE NOTE**: Each applicant must also submit a resume or curriculum vitae (CV) listing, ALL employment and other work related history. Include information for at least the past ten years.

1. Position Title: _____ From: _____ To: _____

   Name & Address of Institution or Provider: _____
   _____

   Telephone _____ Supervisor/Title _____

   Type of Practice/Hospital Unit/Specialty _____

   Duties _____
   _____

   Full Time ☐☐☐☐   Part Time ☐☐☐☐☐☐   Volunteer ☐☐☐☐☐☐   Paid ☐☐☐☐

   - Number of hours worked/volunteered per week _____
   - Number of weeks worked per year _____
   - Total number of years (round to nearest quarter) in position _____
   - If less than one year, number of months in position _____
   - Reason for leaving (if applicable) _____
   _____

2. Position Title: _____ From: _____ To: _____

   Name & Address of Institution or Provider: _____
   _____

   Telephone _____ Supervisor/Title _____

   Type of Practice/Hospital Unit/Specialty _____

   Duties _____
   _____

   Full Time ☐   Part Time ☐   Volunteer ☐   Paid ☐

   - Number of hours worked/volunteered per week _____
   - Number of weeks worked per year _____
   - Total number of years (round to nearest quarter) in position _____
   - If less than one year, number of months in position _____
   - Reason for leaving (if applicable) _____
   _____

3. Position Title: _____ From: _____ To: _____

   Name & Address of Institution or Provider: _____
   _____

   Telephone _____ Supervisor/Title _____

   Type of Practice/Hospital Unit/Specialty _____

   Duties _____
   _____

   Full Time ☐☐☐☐   Part Time ☐☐☐☐☐☐   Volunteer ☐☐☐☐☐☐☐   Paid ☐☐☐☐

   - Number of hours worked/volunteered per week _____
   - Number of weeks worked per year _____
   - Total number of years (round to nearest quarter) in position _____
   - If less than one year, number of months in position _____
   - Reason for leaving (if applicable) _____
     _____

4. Position Title: _____ From: _____ To: _____

   Name & Address of Institution or Provider: _____
   _____

   Telephone _____ Supervisor/Title _____

   Type of Practice/Hospital Unit/Specialty _____

   Duties _____
   _____

   Full Time ☐☐☐☐   Part Time ☐☐☐☐☐☐   Volunteer ☐☐☐☐☐☐☐   Paid ☐☐☐☐

   - Number of hours worked/volunteered per week _____
   - Number of weeks worked per year _____
   - Total number of years (round to nearest quarter) in position _____
   - If less than one year, number of months in position _____
   - Reason for leaving (if applicable) _____
     _____

Health Care Experience Verification

If you are declaring health care experience you must follow these instructions. Absolutely no credit will be granted for any health care experience documented above without providing the following verification document(s).

All health Care experience documented must be verified by providing the following:

1.Letter from Human Resources department, on company letterhead, certifying the following:

      a.   Employment dates
      b.   Position/Title
      c.   Hours worked per week.
      d.   Signature and contact information for Human Resources personnel providing certification.

2.Submit verification letter(s) in a sealed envelope with your completed application on or prior to the application deadline of October 15 to Miami Dade College, Medical Campus
New Student Center 950 N.W. 20th Street, Room 1113 Miami, FL 33127.

CERTIFICATION/REGISTRATION/LICENSURE

_____   _____
Student Name (Print)   **MDC Student Number**

- Do you have any professional Certifications? ☐No ☐Yes
- Do you have any professional Registrations? ☐No ☐Yes
- Do you have any professional Licensures? ☐No ☐Yes

Please list in the spaces provided any health related certifications, registrations or licensures. ***Attach copy of certifications, registrations and/or licensures to this form.***

Has your licensure/registration/certification ever been withdrawn or have been denied certification/registration/licensure? ☐No ☐Yes

If yes, please explain reason here: _____
_____
_____
_____

1. Type of Cert./Lic./Reg.: _____State: _____No:_____
   Date Received: _____Expiration Date:_____

2. Type of Cert./Lic./Reg.: _____State: _____No:_____
   Date Received: _____Expiration Date:_____

3. Type of Cert./Lic./Reg.: _____State: _____No:_____
   Date Received: _____Expiration Date:_____

4. Type of Cert./Lic./Reg.: _____State: _____No:_____
   Date Received: _____Expiration Date:_____

A conviction may affect licensure. For additional information, please contact Department of Profession Regulation.

Licensure as a physician assistant may be affected by previous Licensure/registration/certification denials or withdrawals.

REFERENCE LIST
(Three letters of recommendation are required)

_____   _____
Student Name (Print)   **MDC Student Number**

Please list the individuals you have asked to provide a reference. The Letters of Recommendation must be on letterhead. We reserve the right to contact your references to verify authenticity.

Letters are due with the application by October 15th. Two of the three must be from a healthcare provider such as a MD, DO, PA-C, or ARNP. (Use an additional page to list additional references if needed.)

1. Name: _____ Title: _____

   Relationship to applicant: _____

   Telephone Number: (_____) _____

2. Name: _____ Title: _____

   Relationship to applicant: _____

   Telephone Number: (_____) _____

3. Name: _____ Title: _____

   Relationship to applicant: _____

   Telephone Number: (_____) _____

THE LETTERS OF REFERENCE MUST BE PART OF THIS PACKAGE PRIOR TO SUBMISSION.   THEY CAN NOT BE FAXED, EMAILED, OR SENT VIA THE U.S. MAIL. THE LETTERS OF REFERENCE MUST BE ORIGINAL DOCUMENTS.

SHADOWING EXPERIENCE FORM
To be completed by the Practitioner

As a Miami Dade College physician assistant applicant, I understand that **50 hours of clinical and/or shadowing experience is highly recommended for all applicants without any healthcare experience**. Each separate experience should be documented on separate forms, therefore please make copies of this form as necessary for additional experiences.

Applicant's Name: _____

_____   _____
Applicant's Telephone Number   Applicant's Email Address:

Clinical Setting:
- o Hospital
- o Private Office
- o Clinic
- o Other _____

Specialty_____

_____   _____
Dates of Experience   Estimated Hours of Experience

Supervising Practitioner Information

Name: _____

Phone Number: _____

Address: _____

Signature: _____

Please provide a brief description of supervising Practitioner's duties and responsibilities witnessed by the applicant: _____

_____

_____

_____

_____

*****Can be PA, MD, DO, or NP**