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 collaborating 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).
# Miami Dade College Physician Assistant Application

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PHYSICIAN ASSISTANT PROGRAM APPLICATION PACKET INSTRUCTIONS

Student Name (Print) ______________________________ MDC Student Number ______________________________

The information in this application packet must be completed to be considered an applicant for the Physician Assistant program at Miami Dade College. It is the applicant’s responsibility to provide all necessary documentation 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: Application to Miami Dade College – Applicants who have not enrolled in a 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](https://sisvsr.mdc.edu/admission/ssncaveat.aspx?type=N)

- Submit your high school and college and/or university transcript to the 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

General Information and Requirements:

- **To obtain knowledge about the PA profession:** This is extremely important and will make you a stronger, more informed applicant who is confident and secure in your choice of a career for the Physician Assistant program at Miami Dade College. An excellent place to begin learning what you need to know about the profession is the American Academy of Physician Assistants’ website at [http://www.aapa.org](http://www.aapa.org) and the Florida Academy of Physician Assistants [www.fapaonline.org](http://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 **November 15th** of the year in which you are applying.

- **Additional Prerequisite Course Requirement:** Effective 2012-1 (August 1, 2012), successful completion of **HSC 003 – Introduction to Health Care** will be required for all students applying to the program. It is part of the prerequisites and must be completed prior to the application deadline.

- **Minimum Requirements:** The **minimum overall GPA** for PA applicants is **3.0** and the **minimum natural science GPA** is **3.0**. Please note that meeting the program’s minimum requirements neither guarantees an admission test, interview nor admission to the program.

- **Baccalaureate degree or higher preferred.** (Effective date: November 15th 2017).

- Please send all necessary documents together with the Physician Assistant Application checklist to the address below. Applications will not be accepted if documents are missing.

Submit or Mail Application with all required documents to:

Physician Assistant Program
Miami Dade College, Medical Center Campus Jackie Martinez
950 N.W. 20th Street, Suite 2204 Building #2 Phone: (305) 237-4103
Miami, FL 33127 Email: jhernan7@mdc.edu
This completed PA Application Checklist should accompany each Application Packet no later than November 15th of the year in which you are applying.

NO EXCEPTIONS

<table>
<thead>
<tr>
<th>REQUIRED ITEMS/INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Assistant Application Packet Instructions (Page 3)</td>
</tr>
</tbody>
</table>

**Step One:**
Application for College Admission may also be filled out online at [https://sisvsr.mdc.edu/admission/ssncavet.asp?type=N](https://sisvsr.mdc.edu/admission/ssncavet.asp?type=N)

- **Application for Program Selection - MDC Application (Pages 7-8)**
  - Applicants who have not enrolled in a 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 apply to MDC but the admission fee is waived. (You will receive a MDC Student ID Number)
  - Applicants need a Miami Dade College Student ID Number prior to applying to MDC PA Program

**Step Two:**
Application for MDC PA Program as listed below: Each form must be completed in detail.

- **Physician Assistant Application Checklist** (Pages 4-5)
  - **Program Application Transaction Record** (Page 9)
    - All applicants when applying to MDC PA Program, must pay a $25 application fee.
    - Receipt for Application Fee - $25 indicating program 23080

**Miami Dade College Physician Assistant Application** (Pages 11-13)

**Transfer Credit Review Form** (Pages 14)
Each applicant must also submit official transcripts to the MDC Transcript Processing Services

- If you have taken pre-requisite from another institution, please submit an unofficial and/or official transcript with this package in addition to sending the official transcripts to the MDC Transcript Processing Services- for easier review by the PA Admission Committee.

If you have taken pre-requisite from another institution, please submit an unofficial and/or official transcript with this package in addition to sending the official transcripts to the MDC Transcript Processing Services - for easier review by the PA Admission Committee.
Failure to submit transcripts: Applicants are required to submit transcripts from all institutions attended. Failure to submit complete transcripts may result in: forfeiting your application or dismissal from the PA program after admission. Applicants are required to disclose information about previous admission to other professional programs.

- **UEXcel Credit by Exam**: Miami Dade College uses the minimum scores, credits, and guidelines for awarding credit for exams established by the State of Florida’s Articulation Coordinating Committee (ACC). The link below indicates how UEXcel credit will be utilized at MDC. [https://www.mdc.edu/main/images/UEXCEL_Chart_effective_3-01-2016_tcm6-104626.pdf](https://www.mdc.edu/main/images/UEXCEL_Chart_effective_3-01-2016_tcm6-104626.pdf)

All interested students are encouraged to see an Academic Advisor before registering for the examinations. For additional information on UEXCEL please visit: [http://www.excelsior.edu/exams/uexcel-home](http://www.excelsior.edu/exams/uexcel-home)

- Proof of completion of Foreign Medical Graduate degree, US or foreign Bachelor’s degree or higher – must be approved by MDC transcript evaluator. Please visit the New Student Center prior to submitting this application.

### Health Care Experience Form (Pages 15-16)

- Each applicant must submit Cover Letter, Resume or Curriculum Vitae (CV) with application packet

### Certification/Registration/Licensure Form (Page 18)

- Each applicant must submit copies of certification/registration/licensure with application packet

### Reference List Form (Page 19)

- Three Recommendation letters are required, at least one from a health professional. Letters of Recommendation must be on letterhead, and must be included as part of the application package. **DO NOT FAX, E-MAIL, OR SENT VIA THE US MAIL.**

### Shadowing Experience Form (Page 20)

- For candidates 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 **November 15th** of the year in which you are applying.

**Class Preference**: (Students will spend 25–30 hours in class). Classes can be schedule as follow:

**Day Class, Medical Center Campus** – Monday - Friday: 8:00 am – 9:00 pm. Certain weekend classes may be scheduled.
Step One

Application for College Admission may also be filled out online at
https://sisvsr.mdc.edu/admission/ssncaveat.aspx?type=N

- Application for Program Selection (MDC Application)

- Applicants who have not taken a class at MDC previously, must apply to MDC for admission and pay a $30 admission fee. Applicants who have taken classes at MDC previously but have not taken a class in the last 12 months, must apply to MDC but the admission fee is waived.

- Applicants need a Miami Dade College Student ID Number prior to applying to MDC PA Program
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)

<table>
<thead>
<tr>
<th>School Name</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Attendance Dates</th>
<th>Degrees or # of credits earned &amp; major</th>
</tr>
</thead>
<tbody>
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<td>From Mo/Yr to Mo/Yr</td>
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</tbody>
</table>

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

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<tr>
<th>School Name</th>
<th>City</th>
<th>State</th>
<th>Country</th>
<th>Attendance Dates</th>
<th>Degrees or # of credits earned &amp; major</th>
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</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
<td>From Mo/Yr to Mo/Yr</td>
<td></td>
</tr>
</tbody>
</table>

PROGRAM FOR WHICH YOU ARE APPLYING:

(See Reverse Side)

TERM FOR WHICH YOU ARE APPLYING:
Nursing Students Only:
Fall (Aug-Dec)  Spring (Jan-Apr)  Summer (May-Jul)  Year:
___  ___  ___  ___
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
Step Two

Miami Dade College Physician Assistant Program Application

- Program Application Transaction Record ......................................................... Page 9
- Miami Dade College Physician Assistant Application.............................. Pages 10-12
- Transfer Credit Review Form .................................................................................... Pages 13-14
- Health Care Experience Form .................................................................................. Pages 15
- Cover Letter, Resume or Curriculum Vitae ............................................................ Page 16
- Certification/Registration/Licensure Form ............................................................... Page 17
- Reference List Form ................................................................................................... Page 18
- Shadowing Experience Form ....................................................................................... Page 19
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.**

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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**

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<tr>
<th>ACCOUNT #</th>
<th>AMOUNT PAID:</th>
<th>DATE PAID:</th>
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<tr>
<td>#1009000-D19000-90-40503</td>
<td>____________________</td>
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</tbody>
</table>

**RECEIPT #:** ____________________

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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_________________________

Email #1_________________________  Email #2_________________________

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  □ Visa Student (Specify) __________________________________________________________

4. Native Language -  □ English  □ Spanish  □ French  □ Creole  □ Other (Specify) __________________________________________________________
III. PROGRAM INTENTIONS AND MIAMI DADE COLLEGE ENROLLMENT STATUS

Program for which you are applying: Health Science Program – 2308

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.)

<table>
<thead>
<tr>
<th>School Name</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Date Graduated or will Graduate (Mo./Yr.)</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>School Name</th>
<th>City</th>
<th>State</th>
<th>Attendant Date From (Mo./Yr.)</th>
<th>To (Mo./Yr.)</th>
<th>Degrees or Number of Credits earned</th>
</tr>
</thead>
</table>

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?

1. □ No  
2. □ 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 contiders, or for which you were adjudicated or adjudication was withheld because of placement in a pre-trial intervention program?

1. □ No  
2. □ 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
I have submitted an application, application fee and have requested that my transcripts 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**

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<thead>
<tr>
<th>Requirement(s)</th>
<th>College/University</th>
<th>Year</th>
<th>Equivalent Course #</th>
<th>Equivalent Course Title</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. General Education Requirements</strong></td>
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<tr>
<td>1. COMMUNICATIONS</td>
<td>(3 credits Required)</td>
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<tr>
<td>ENC 1101</td>
<td>English Composition 1</td>
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<tr>
<td>2. HUMANITIES</td>
<td>(3 credits Required)</td>
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<tr>
<td>HUM 1020</td>
<td>Humanities</td>
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<tr>
<td>3. BEHAVIORAL AND SOCIAL SCIENCE</td>
<td>(3 credits Required)</td>
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<tr>
<td>PSY 2012</td>
<td>Introduction to Psychology</td>
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<tr>
<td>4. NATURAL SCIENCE</td>
<td>(3 credits Required)</td>
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<tr>
<td>BSC 2085</td>
<td>Human Anatomy and Physiology I</td>
<td></td>
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<tr>
<td>5. MATHEMATICS</td>
<td>(6 credits Required)</td>
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<tr>
<td>➔ MAC 1105</td>
<td>College Algebra</td>
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<td>➔ STA 2023</td>
<td>Statistical Methods</td>
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<td>6. COMPUTER COMPETENCY</td>
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<tr>
<td>CGS 1060</td>
<td>Intro. To Microcomputer Usage</td>
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<td>7. FOREIGN LANGUAGE</td>
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<td>XXX1121 or CLEP or HS or ASL 1150C</td>
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<tr>
<td>8. MAJOR CORE REQUIREMENTS</td>
<td>(23 credits Required)</td>
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<tr>
<td>BSC 2085</td>
<td>Human Anatomy and Physiology I</td>
<td>(3 credits)</td>
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<tr>
<td>BSC 2085L</td>
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<td>(1 credit)</td>
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<td>Requirement(s)</td>
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<td>Term and Year</td>
<td>Equivalent Course #</td>
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<td><strong>MDC Course #</strong></td>
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<td>CHM 1045</td>
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<td>CHM 1046</td>
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<td>CHM 1046L</td>
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<tr>
<td>MCB 2010</td>
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<td>(3 credits)</td>
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<tr>
<td>Microbiology</td>
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<td>MCB 2010L</td>
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<td>Microbiology Lab</td>
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<td><strong>9. INTRODUCTION TO HEALTHCARE</strong></td>
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<tr>
<td><strong>INSTITUTIONAL REQUIREMENT</strong></td>
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<td>HSC 0003</td>
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<td>Intro. to Health Care</td>
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<td><strong>II. Highly Recommended Courses</strong></td>
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<td>(required in order to confer the BAS in Health Sciences with a concentration in Physician Assistant)</td>
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<td>ENC 1102</td>
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<td>English Composition 2</td>
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<td>SPC 1017</td>
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<td>Fundamentals of Speech Communication</td>
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<td>PHI 2604</td>
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<td>Critical Thinking/Ethics</td>
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<td>DEP 2000</td>
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<td>Human Growth and Development</td>
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**NOTE:** The above pre-requisite courses must be completed with a grade of “C” or better. All Sciences courses taken more than five years ago must be repeated – Lecture only. Each applicant must also submit transcripts to the Physician Assistant Program.
HEALTH CARE EXPERIENCE FORM
(Each form must be completed in full)

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) ______________________________________________________________________________________________
Resume
or
Curriculum Vitae

- Each applicant must submit a Resume or Curriculum Vitae (CV) with the application packet.
CERTIFICATION/REGISTRATION/LICENSURE
(Each form must be completed in full)

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)

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.

While only (3) references are required, you may elect to ask more than four individuals to submit references on your behalf to insure that the program receives at least (3) by the deadline. (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: (____) ________________________________

4. Name: ____________________________________________ Title: ______________________________
   Relationship to applicant: ________________________________________________________________
   Telephone Number: (____) ________________________________

THE LETTERS OF REFERENCE MUST BE PART OF THIS PACKAGE PRIOR TO SUBMISSION. THEY CANNOT BE FAXED, EMAILED, OR SENT VIA THE US 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 one form, so you will need to photocopy this form as necessary for additional experiences.

| Applicant’s Name: | ________________________________ | | Applicant’s Email Address: | ________________________________ |
|-------------------|----------------------------------|-------------------|---------------------------|

Clinical Setting:
- Hospital
- Private Office
- Clinic
- 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