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).
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 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](https://sisvsr.mdc.edu/admission/ssncaveat.aspx?type=N) 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

General Information and Requirements:

- **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](http://www.aapa.org)’s website at 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 15**th of the year in which you are applying.

- **Course Requirement:** Effective Fall 2012, successful completion of HSC 0003 – Introduction to Health Care/Lab will be required for all students applying to the program and must be completed prior to the application deadline.

- **Minimum Requirements:** The minimum cumulative 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 is preferred.** (Effective date: November 15**th** 2017).

- All application documents must be received no later than November 15**th** of the year in which you are applying. Applications will not be accepted if ANY documentation is lacking.

Submit or mail application with all required documents to: (Do not turn in applications to PA program directly. Please submit to the New Student Center in person or by mail.)
Miami Dade College, Medical Center Campus
New Student Center
950 N.W. 20th Street, Room 1113
## PHYSICIAN ASSISTANT APPLICATION CHECKLIST

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

### Student Name (Print)  
MDC Student Number

<table>
<thead>
<tr>
<th>REQUIRED ITEMS/INFORMATION</th>
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</thead>
</table>
   - 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  
   - Each applicant must also submit official transcripts to the MDC Transcript Processing Services.  
     - The College requires 4-6 weeks to process domestic transcripts and 6-8 weeks for international 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  |
| 6  | Cover Letter, 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 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 SEND VIA THE US 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 November 15th of the year in which you are applying.  |
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>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>From Mo/Yr to Mo/Yr</td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<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, 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 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 ____________________________

ACCOUNT #1009000-D19000-90-40503

__________________________________________________________________________________________

AMOUNT PAID: ____________________________
DATE PAID: ____________________________
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

<table>
<thead>
<tr>
<th>Student Name (Print)</th>
<th>MDC Student Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MDC Student E-Mail</th>
<th>Personal E-Mail</th>
</tr>
</thead>
</table>

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 – 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.)*

<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>
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</thead>
<tbody>
<tr>
<td>_____________</td>
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</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.) To (Mo./Yr.)</th>
<th>Degrees or Number of Credits earned</th>
</tr>
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<tr>
<td>_____________</td>
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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 conters 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

<table>
<thead>
<tr>
<th>MDC Course Requirements</th>
<th>College/University</th>
<th>Year</th>
<th>Equivalent Course #</th>
<th>Equivalent Course Title</th>
<th>Grade</th>
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</thead>
<tbody>
<tr>
<td>English Composition (3 credits): ENC 1101</td>
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<tr>
<td>Fundamentals of Speech Communication (3 credits): SPC 1017</td>
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<tr>
<td>Critical Thinking/Ethics (3 credits): PHI 2604</td>
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<tr>
<td>Human Growth and Development (3 credits): DEP2000</td>
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<tr>
<td>Statistical Methods (3 credits): STA2023</td>
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<tr>
<td>Science Requirements:</td>
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<tr>
<td>Human Anatomy and Physiology</td>
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<tr>
<td>with Lab (4 credits): BSC 2085/L</td>
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<tr>
<td>Human Anatomy and Physiology II</td>
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<tr>
<td>with Lab (4 credits): BSC 2086/L</td>
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<tr>
<td>General Chemistry and Qualitative Analysis I with Lab (5 credits): CHM 1045/L</td>
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<tr>
<td>General Chemistry and Qualitative Analysis II with Lab (5 credits): CHM 1046/L</td>
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<tr>
<td>Microbiology and Lab (5 credits): MCB 2010/L</td>
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<tr>
<td>Introduction to Healthcare with Lab (3 credits): HSC003/L</td>
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<tr>
<td>Computer Competency (4 credits or CPT Exam)</td>
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<tr>
<td>Highly Recommended Courses</td>
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<tr>
<td>(required in order to confer the BAS in Health Sciences with a concentration in Physician Assistant)</td>
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<tr>
<td>English Composition 2 (3 credits): ENC 1102</td>
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<tr>
<td>Humanities (3 credits Required)</td>
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<tr>
<td>Mathematics (3 credits): College Algebra</td>
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<tr>
<td>recommended</td>
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<tr>
<td>History of the United States since 1877(3 credits): AMH 2020 recommended</td>
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<tr>
<td>Foreign Language XXX1121 or CLEP or HS or ASL 1150C</td>
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NOTE: The above pre-requisite courses must be completed with a grade of “C” or better. All science lecture courses taken more than five years ago must be repeated.
Foreign Physicians: All science lecture courses taken more than ten years ago must be repeated

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) ____________________________________________________________

_________________________________________________________________________________________
<table>
<thead>
<tr>
<th>Student Name (Print)</th>
<th>MDC Student Number</th>
</tr>
</thead>
</table>

- 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.

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: (____) _________________________________

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