Miami Dade College
Physician Assistant Program

Physician Assistant (Associate in Science Degree)

Graduates of this program are prepared for employment as members of the health care delivery team to work under the direct supervision of a licensed physician. Students are instructed in various aspects of medical care, theory, instrumentation, diagnosis and treatment, including the prescribing and administration of drugs. There is a concentration in behavioral, biological, and physician assistant courses combined with hospital and office practice under the supervision of licensed health care providers. Graduates are eligible to sit for the National Commission on Certification of Physician Assistants (NCCPA) Examination. This program has been fully accredited by the Accreditation Review Commission on Education for the Physician Assistant, Inc. (ARC-PA).
# 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/admission2/menu15.aspx.
- 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 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 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 – This applies to applicants applying for the November 15th, 2017 deadline).

- 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
950 N.W. 20th Street, Suite 2204 Building #2
Miami, FL 33127

Jackie Martinez
Phone: (305) 237-4103
Email: jhernan7@mdc.edu
PHYSICIAN ASSISTANT APPLICATION CHECKLIST

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

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

REQUIED ITEMS/INFORMATION

| Physician Assistant Application Packet Instructions (Page 3) |

<table>
<thead>
<tr>
<th>Step One: Application for College Admission may also be filled out online at <a href="https://sisvsr.mdc.edu/admission2/menu15.aspx">https://sisvsr.mdc.edu/admission2/menu15.aspx</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Application for Program Selection - MDC Application (Pages 7-8)</td>
</tr>
<tr>
<td>• 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)</td>
</tr>
<tr>
<td>• Applicants need a Miami Dade College Student ID Number prior to applying to MDC PA Program</td>
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<thead>
<tr>
<th>Step Two: Application for MDC PA Program as listed below: Each form must be completed in detail.</th>
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<tbody>
<tr>
<td>• Physician Assistant Application Checklist (Pages 4-5)</td>
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<thead>
<tr>
<th>Program Application Transaction Record (Page 10)</th>
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<tbody>
<tr>
<td>• All applicants when applying to MDC PA Program, must pay a $25 application fee.</td>
</tr>
<tr>
<td>• Receipt for Application Fee - $25 indicating program 23060</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Miami Dade College Physician Assistant Application (Pages 11-13)</th>
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<tbody>
<tr>
<td>• Transfer Credit Review Form (Pages 14)</td>
</tr>
<tr>
<td>Each applicant must also <strong>submit official transcripts</strong> to the MDC Transcript Processing Services</td>
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</tbody>
</table>
- 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.
  - **Proof of completion of Foreign Medical Graduate, 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 also submit **Cover Letter, Resume or Curriculum Vitae (CV) with your application packet**

**Certification/Registration/Licensure Form (Page 18)**
- Each applicant must also submit copies of certification/registration/licensure with your application packet

**Reference List Form (Page 19)**
- Letters of Recommendation must be on letterhead - Submission of 3 (three) Recommendation letters with at least one from a health professional.) **THE LETTERS OF REFERENCE MUST BE PART OF THIS PACKAGE PRIOR TO SUBMISSION. THEY CAN’T BE FAXED, EMAILED, OR SENT VIA THE US MAIL.**

**Shadowing Experience Form (Page 20)**
- 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.

**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. |

| Name of person receiving application (print) | Date received |
Step One

Application for College Admission may also be filled out online at https://sisvsr.mdc.edu/admission2/menu15.aspx

- Application for Program Selection (MDC Application)

- If you haven’t taken a class at MDC previously, applicants 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.

- Applicants need a Miami Dade College Student ID Number prior to applying to MDC PA Program
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<thead>
<tr>
<th>Last Name (Print)</th>
<th>First</th>
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<tr>
<th>Student Number</th>
<th>Email address</th>
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<tr>
<th>Address</th>
<th>Apt#</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<thead>
<tr>
<th>Telephone Number</th>
<th>Day phone</th>
<th>Evening Phone</th>
<th>Alternate phone</th>
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</table>

**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 From Mo/yr to Mo/yr</th>
<th>Degrees or # of credits earned &amp; major</th>
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**Vocational School, College, University (Attach list if more than two)**

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<th>School Name</th>
<th>City</th>
<th>State</th>
<th>Country</th>
<th>Attendance Dates From Mo/yr to Mo/yr</th>
<th>Degrees or # of credits earned &amp; major</th>
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**PROGRAM FOR WHICH YOU ARE APPLYING:**

(See Reverse Side)

**TERM FOR WHICH YOU ARE APPLYING:**

- Fall (Aug-Dec)  
- Spring (Jan-Apr)  
- Summer (May-Jul)  

Nursing Students Only:

- Full time  
- Part time  
- Accelerated  
- Bridge  
- Generic  
- Medical Center Campus  
- 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
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
- Health Care Experience Form ................................................................. Pages 14-15
- Cover Letter, Resume or Curriculum Vitae ............................................... Page 16
- Certification/Registration/Licensure Form .................................................. Page 17
- Reference List Form .................................................................................. Page 18
- Shadowing Experience Form ..................................................................... Page 19
MIAMI DADE COLLEGE MEDICAL CENTER
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
_____ **Physician Assistant-23060**
_____ Radiography-A3036
_____ Respiratory Therapy-23045
_____ Veterinary Technology-23062

_________________________   __________________________
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.
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: **Physician Assistant Program – 23060**

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

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<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>
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<th>School Name</th>
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<th>Attendant Date From (Mo./Yr.) To (Mo./Yr.)</th>
<th>Degrees or Number of Credits earned</th>
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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?

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 contenders, 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
TRANSFER CREDIT REVIEW FORM
(Each form must be completed in full)

I have submitted an application, application fee and have requested that my transcripts. The following courses will transfer and meet the requirements of the Physician Assistant Program. This will be reviewed by a transcript evaluator.

________________________________________  ______________________________
Student Name (Print)     MDC Student Number

RECORD OF PREREQUISITE COURSES

<table>
<thead>
<tr>
<th>Requirement(s)</th>
<th>MDC Course #</th>
<th>College/University</th>
<th>Year</th>
<th>Equivalent Course #</th>
<th>Equivalent Course Title</th>
<th>Grade</th>
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<tbody>
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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 copies of each 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.)

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<tbody>
<tr>
<td>1.</td>
<td>Name:________________________________________</td>
<td>Title:____________________</td>
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<td>Relationship to applicant: ______________________</td>
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<td>Telephone Number: (____) ________________________</td>
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<td>2.</td>
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<td>Telephone Number: (____) ________________________</td>
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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.
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.

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<tr>
<th>Applicant’s Name:</th>
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<thead>
<tr>
<th>Applicant’s Telephone Number</th>
<th>Applicant’s Email Address:</th>
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Clinical Setting:
- [ ] Hospital
- [ ] Private Office
- [ ] Clinic
- [ ] Other ________________________________

Specialty ________________________________________________________________

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<tr>
<th>Dates of Experience</th>
<th>Estimated Hours of Experience</th>
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**Supervising Practitioner Information**

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<th>Name:</th>
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<th>Phone Number:</th>
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<th>Address:</th>
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<th>Signature:</th>
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Please provide a brief description of supervising Practitioner’s duties and responsibilities witnessed by the applicant:

- ________________________________________________________________
- ________________________________________________________________
- ________________________________________________________________
- ________________________________________________________________

*Can be PA, MD, DO, or NP