



# ShadowMatch 111

## PHYSICIAN ASSISTANT SHADOWING VERIFICATION

### Instructions

Please complete this form to verify that you have participated in an experience with a practicing physician assistant. This experience can be in the form of shadowing, internship, volunteer or work experience.

### Applicant Information

Name \_\_\_\_\_  
First Middle Initial Last

Current Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Shadowing Experience

Institution/Location \_\_\_\_\_

Date(s) of Experience \_\_\_\_\_

Total Number of Hours \_\_\_\_\_

### Physician Assistant Information

Name \_\_\_\_\_

Workplace \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I verify that the above named applicant participated in an opportunity to explore the physician assistant profession by spending time observing me in practice.

\_\_\_\_\_  
Physician Assistant Signature

\_\_\_\_\_  
Date