As a prerequisite for the Master of Physician Assistant Practice (MPAP) program at the University of Dayton, you are required to complete 250 hours of health care experience. This time can be met through employment or volunteer activities in direct patient care, observation or shadowing time in a health care setting. Please use the following information to plan and record your observation time correctly. This form is not valid without a supervisor’s signature.

**OBSERVATION REQUIREMENTS FOR MASTER OF PHYSICIAN ASSISTANT PRACTICE (MPAP)**

- A total of 250 hours of observation is required.
- Use only one verification form per facility or institution. Feel free to make copies of this form as needed.

**Facility Information**

- **Facility Name**:___________________________________________
- **Facility Telephone**: (______)___________________________
- **Facility Mailing Address**:______________________________________________________________________________________
- **Type of Setting**:_________________________________________________________________________________________

**Clinical Observation/Work Experience**

- From (MM/DD/YY)___________ To (MM/DD/YY)___________ Number of hours____

**I have observed/Performed the following patient-related activities:**

- __________________________________________________________________________
- __________________________________________________________________________
- __________________________________________________________________________
- __________________________________________________________________________
- __________________________________________________________________________
- __________________________________________________________________________
- __________________________________________________________________________

**Applicant’s signature**___________________________________________________________ Date________________________

**SUPERVISOR INFORMATION** (To be completed by supervisor)

I hereby verify that the above information is true and accurate.

- **Supervisor’s Signature**________________________________ Print Name ___________________________
- **Date**________________________ Telephone Number (______)___________________________

Thank you for making a contribution to the application process for future physician assistants. If you have any comments regarding this applicant’s potential as a physician assistant, please write them on the back of this form or feel free to contact us.

**SUBMIT COMPLETED FORM TO**

Physician Assistant Program  
300 College Park  
Dayton, OH 45469-2958  
Phone: 937-229-2900 | Fax: 937-229-2903