As a prerequisite for the Master of Physician Assistant Practice (MPAP) program at the University of Dayton, you are required to complete 20 hours of physician assistant shadowing experience. Please use the following information to plan and record your observation time correctly. This form is not valid without a physician assistant’s signature. The applicant is responsible for arranging the shadowing experience.

**SHADOWING REQUIREMENTS FOR THE MASTER OF PHYSICIAN ASSISTANT PRACTICE (MPAP)**

- A total of 20 hours of PA shadowing is required.
- Shadowing must be with an NCCPA-certified physician assistant.
- Use only one form per facility or institution. Feel free to make copies as needed.

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**Facility Name**___________________________________________  **Facility Telephone** (______)___________________________

**Facility Mailing Address**______________________________________________________________________________________

**Type of Setting**_________________________________________________________________________________________

**Physician Assistant Shadowing/Work Experience:** From (MM/DD/YY)___________ To (MM/DD/YY)___________

   Number of hours_____

I have observed/performed the following patient-related activities:

__________________________________________________________________________________________________________

__________________________________________________________________________________________________________

__________________________________________________________________________________________________________

__________________________________________________________________________________________________________

__________________________________________________________________________________________________________

__________________________________________________________________________________________________________

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**Applicant’s signature**___________________________________________  **Date**____________

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**PHYSICIAN ASSISTANT INFORMATION** (To be completed by physician assistant)

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

**Physician Assistant’s Signature**___________________________________________  **Print Name** ________________________________

**Date**________________________  **Telephone Number** (______)___________________________

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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.

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**CONTACT**

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