CLINICAL OBSERVATION VERIFICATION FORM



Application Cycle:_

Applicant:				
Last Na	me	First Name	Middle Name	
Date of Birth:		CASPA ID Number:		
required to complete 250 activities in direct patient of	hours of <u>health</u> care, observatio	<u>care experience.</u> This time con nor shadowing time in a hea	program at the University of Dayton, you are in be met through employment or volunteer Ith care setting. Please use the following i is not valid without a supervisor's signature.	
OBSERVATION REQUIREM	MENTS FOR MA	STER OF PHYSICIAN ASSISTA	ANTPRACTICE (MPAP)	
A total of 250 hours of a	observation is req	uired.		
Use only one verification	ı form per facility	or institution. Feel free to make	copies of this form as needed.	
Facility Name		Facility Telephone ()		
Facility Mailing Address				
Type of Setting				
Clinical Observation/Work Exp	perience: From (<i>N</i>	MM/DD/YY) To (MM	1/DD/YY) Number of hours	
I have observed/performed the	ne following pation	ent-related activities:		
Applicant's signature			Date	
SUPERVISOR INFORMATIO	N (To be comple	ted by supervisor)		
I hereby verify that the above	information is tru	e and accurate.		
Date		Telephone Number	()	
			ian assistants. If you have any comments tact us: Paprogram@udayton.edu	

How to upload completed forms: Once signatures are obtained it is the applicants responsibility to upload the forms to their CASPA application portal. Click on the Program Materials icon, choose the <u>Documents</u> tab. Clinical hours should be uploaded to the "Shadowing/Healthcare Hours" tab; Community service hours should be uploaded to the "Other" tab. This can be done while completing the application or after you have submitted it. Please do not email forms