



## Physician Assistant Program

### PHYSICIAN ASSISTANT SHADOWING DOCUMENTATION

APPLICANT/STUDENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

NAME OF PHYSICIAN ASSISTANT AND CONTACT INFORMATION	SPECIALITY	DATE OF SHADOWING	# OF HOURS

*Please bring this completed form with you to your on-campus interview. After you interview, if you have additional hours to submit, please submit by fax to: 724.830.1891 or by mail to: Seton Hill University, Office of Graduate and Adult Studies, 1 Seton Hill Drive Box 510F, Greensburg, PA 15601*

I hereby verify that the above information is true and accurate and subject to verification:

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*(Signature of Student)*