PHYSICIAN ASSISTANT STUDENT OBSERVATION DOCUMENTATION

TO BE COMPLETED BY STUDENT

Student Name: ____________________

Name of Facility: ____________________ Street Address for Facility: ____________________

City: ____________________ State: ________ Zip Code: ____________________

Physician Assistant Name: ____________________

PA Email Address: ____________________ PA Phone: ____________________

Type of Facility Setting: ____________________

Date(s) of Clinical Experience or Exposure: From __________ To ____________ Total Hours: ____________________

Description of Clinical Experience or Exposure:

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Student Signature: ____________________ Date: ____________________

TO BE COMPLETED BY PHYSICIAN ASSISTANT

Signature of Supervising PA: ____________________ Date: ________________

PA License Number: ____________________ State: ________________

* These hours are in preparation for application to Master of Physician's Assistant Programs. If there are any questions or concerns, please contact the Pre-Professional Health Programs Office at 216-687-9321 or coshpadvising@csuohio.edu. Please make as many copies of this form as necessary to record your observation/volunteer/paid work hours. Use one form for each practice setting or population.