

# USJ PA STUDIES PROGRAM – 2024 EXPERIENCE VERIFICATION FORM

**PLEASE SEND COMPLETED FORM TO  
PASTUDIESPROGRAM@USJ.EDU AND  
UPLOAD TO YOUR CASPA APPLICATION**



Applicant: \_\_\_\_\_  
Last Name First Name Middle Name

Date of Birth: \_\_\_\_\_ CASPA ID Number: \_\_\_\_\_

## EXPERIENCE REQUIREMENTS FOR THE MASTER OF SCIENCE PHYSICIAN ASSISTANT STUDIES PROGRAM

- A total of 1,000 hours of experience **within the last 5 years** is required in **any combination of the following activities**:
  - Volunteerism, Healthcare Shadowing, Clinical Research, Paid/Volunteer Patient Care Experience
- The program requires verification of 1,000 hours of experience to ensure that every applicant has met the threshold. When scoring an applicant's file, we will review and consider ALL experiences listed by the applicant in CASPA.
- This form is not valid without a supervisor's signature. Use only one form per facility or institution. Feel free to make copies as needed.
- **The applicant is responsible for completing experiences, in any combination of the above listed areas by the 12/20/24 deadline.**

Facility Name \_\_\_\_\_ Facility Telephone ( ) \_\_\_\_\_

Type of Setting \_\_\_\_\_

Volunteerism: From (MM/DD/YY) \_\_\_\_\_ To (MM/DD/YY) \_\_\_\_\_ Total Number of Hours \_\_\_\_\_

Healthcare Shadowing: From (MM/DD/YY) \_\_\_\_\_ To (MM/DD/YY) \_\_\_\_\_ Total Number of Hours \_\_\_\_\_

Clinical Research: From (MM/DD/YY) \_\_\_\_\_ To (MM/DD/YY) \_\_\_\_\_ Total Number of Hours \_\_\_\_\_

Paid/Vol. Patient Care Experience: From (MM/DD/YY) \_\_\_\_\_ To (MM/DD/YY) \_\_\_\_\_ Total Number of Hours \_\_\_\_\_

**My responsibilities or activities in the above setting included:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_

## **SUPERVISOR INFORMATION REQUIRED (TO BE COMPLETED BY SUPERVISOR)** *I hereby verify that the above information is true and accurate*

Supervisor's Signature \_\_\_\_\_ Print Name & Credentials \_\_\_\_\_

Date \_\_\_\_\_ Telephone Number C \_\_\_\_\_ W \_\_\_\_\_ H \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_

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.

## **CONTACT**

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