

West Chester University

DOCUMENTATION SHEET

PHYSICIAN ASSISTANT (PA) OBSERVATION HOURS

FOR STUDENTS ENROLLED IN THE B.S. IN EXERCISE SCIENCE CONCENTRATION

PLEASE PRINT:

Student Name: _____

Name of Facility where student observed: _____

Street Address, City, State of Facility _____

Name of Physician Assistant who supervised you during the observation experience and/or can verify your PA observation hours.

PA License Number _____ State of PA License _____

PA Email Address _____ PA Phone Number _____ - _____ - _____

Type of Experience: _____ Inpatient _____ Outpatient experience _____ Observation only

_____ Paid _____ Volunteer Experience

PA Setting (Select all that apply):

_____ Children and Youth _____ Work and Industry _____ Mental Health

_____ Rehabilitation _____ Health and Wellness _____ Productive Aging

_____ Other _____

Start Date _____ End Date _____

Total Number of Hours Over Span of Experience: _____

Signature of PA: _____

Signature of Student: _____