Miami Dade College
Physician Assistant Program

Physician Assistant (Associate in Science Degree)

Graduates of this program are prepared for employment as members of the health care delivery team to work under the supervision of a licensed physician. Students are instructed in various aspects of medical care, theory, instrumentation, diagnosis and treatment, including the prescribing and administration of drugs. There is a concentration in behavioral, biological, and physician assistant courses combined with hospital and office practice under the supervision of licensed health care providers. Graduates are eligible to sit for the National Commission on Certification of Physician Assistants (NCCPA) Examination. This program has been fully accredited by the Accreditation Review Commission on Education for the Physician Assistant, Inc. (ARC-PA).
Miami Dade College Physician Assistant Program Application

Table of Contents

- Physician Assistant Application Packet Instructions  Page 3
- Physician Assistant Application Checklist  Pages 4-5
- Step One  Page 6
- Application for Program Selection - MDC Application  Pages 7-8
- Step Two  Page 9
- Program Application Transaction Record  Page 10
- Miami Dade College Physician Assistant Application  Pages 11-13
- Transfer Credit Review Form  Pages 14
- Health Care Experience Form  Pages 15-16
- Resume or Curriculum Vitae  Page 17
- Certification/Registration/Licensure Form  Page 18
- Reference List Form  Page 19
- Shadowing Experience Form  Page 20
MIAMI DADE COLLEGE, MEDICAL CAMPUS PHYSICIAN ASSISTANT
PROGRAM APPLICATION PACKET INSTRUCTIONS

Student Name (Print)                                                MDC Student Number

The information in this application packet must be completed to be considered an applicant for the Physician Assistant program at Miami Dade College. It is the applicant’s responsibility to provide all necessary documentation for each of the required content areas. Please be sure to follow the instructions provided to ensure the submission of a complete application packet.

Step 1: Application to Miami Dade College – If you haven’t taken a class at MDC previously or haven’t taken a class in the last 12 months, then applicants must apply to MDC for admission or readmission. (MDC student number is required)

☐ Important for New/Current Student: Miami Dade College Student ID Number - Miami Dade College’s online application makes it quick and easy to apply. After you complete the online application at: https://sisvrs.mdc.edu/admission2/menu15.aspx.
Submit your high school and college and/or university transcript to Miami Dade College Attention: Transcript Processing Services, 11011 SW 104th street, Room 3113.
Miami, FL 33176-3393

Step 2: Application to MDC Physician Assistant Program

General Information and Requirements:

☐ To obtain knowledge about the PA profession: This is extremely important and will make you a stronger, more informed applicant who is confident and secure in your choice of a career for the Physician Assistant program at Miami Dade College. An excellent place to begin learning what you need to know about the profession is the American Academy of Physician Assistants’ website at http://www.aapa.org and the Florida Academy of Physician Assistants www.fapaonline.org

☐ If you don’t have previous medical experience, at least 50 hours of clinical and/or shadowing experience is highly recommended. This needs to be completed prior to January 15th of the year in which you are applying.

☐ Additional Prerequisite Course Requirement: Effective 2012-1 (August 1, 2012), successful completion of HSC 003 – Introduction to Health Care will be required for all students applying to the program. It is part of the prerequisites and must be completed prior to the application deadline.

☐ Minimum Requirements: The minimum overall GPA for PA applicants is 2.5 and the minimum natural science GPA is 2.7. Please note that meeting the program’s minimum requirements neither guarantees an admission test, interview nor admission to the program.

☐ Please send all necessary documents together with the Physician Assistant Application checklist to the address below. Applications will not be accepted if documents are missing.

Submit or mail application with all required documents to:
For more information, contact the program office at 305-237-4103; Jackie Martinez, BS
Physician Assistant Program
Miami Dade College, Medical Campus
950 N.W. 20th Street, Suite 2204 Building #2 Miami, FL 33127
<table>
<thead>
<tr>
<th>REQUIRED ITEMS/INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Assistant Application Packet Instructions</strong> (Page 3)</td>
</tr>
</tbody>
</table>

**Step One:**
Application for College Admission may also be filled out online at [https://sivsrs.mdc.edu/admission2/menu15.aspx](https://sivsrs.mdc.edu/admission2/menu15.aspx)

- **Application for Program Selection - MDC Application** (Pages 7-8)
- If you haven’t taken a class at MDC previously, applicants must apply to MDC for admission and pay a $30 admission fee. If you have taken classes at MDC previously but haven’t taken a class in the last 12 months, you must apply to MDC but the admission fee is waived. (You will receive a MDC Student ID Number)
- Applicants need a Miami Dade College Student ID Number prior to applying to MDC PA Program

**Step Two:**
Application for MDC PA Program as listed below: **Each form must be completed in detail.**

- **Physician Assistant Application Checklist** (Pages 4-5)
- **Program Application Transaction Record** (Page 10)
  - All applicants when applying to MDC PA Program, must pay a $25 application fee.
  - Receipt for **Application Fee** - $25 indicating program 23060
- **Miami Dade College Physician Assistant Application** (Pages 11-13)
- **Transfer Credit Review Form** (Pages 14)
  - Each applicant must also submit official transcripts to the MDC Transcript Processing Services
If you have taken pre-requisites from another institution, please submit an unofficial and/or official transcript with this package in addition to sending the official transcripts to the MDC Transcript Processing Service department - for easier review by the PA Admission Committee.

- Proof of completion of Foreign Medical Graduate, US or foreign Bachelor’s degree or higher – must be approved by MDC transcript evaluator. Please visit the New Student Center prior to submitting this application.

**Health Care Experience Form (Pages 15-16)**

- Each applicant must also submit Resume or Curriculum Vitae (CV) to the Physician Assistant Program

**Certification/Registration/Licensure Form (Page 18)**

- Each applicant must also submit copies of certification/registration/licensure to the Physician Assistant Program

**Reference List Form (Page 19)**

- Letters of Recommendation must be on letterhead - Submission of 3 (three) Recommendation letters with at least one from a health professional.) **THE LETTERS OF REFERENCE MUST BE PART OF THIS PACKAGE PRIOR TO SUBMISSION. THEY CAN’T BE FAXED, EMAILED, OR SENT VIA THE US MAIL.**

**Shadowing Experience Form (Page 20)**

- If you don’t have previous medical experience, at least 50 hours of clinical and/or shadowing experience is highly recommended. This needs to be completed prior to January 15th of the year in which you are applying.

**Class Preference:** (Students will spend 25–30 hours in class). Classes can be schedule as follows:

**Day Class, Medical Campus** – Monday - Friday: 8:00 am – 9:00 pm. Certain weekend classes maybe scheduled.

Name of person receiving application (print)________________________ Date received________________________
Step One

Application for College Admission may also be filled out online at https://sisvsr.mdc.edu/admission2/menu15.aspx

- Application for Program Selection (MDC Application)

- If you haven’t taken a class at MDC previously, applicants must apply to MDC for admission and pay a $30 admission fee. If you have taken classes at MDC previously but haven’t taken a class in the last 12 months, you must apply to MDC but the admission fee is waived.

- Applicants need a Miami Dade College Student ID Number prior to applying to MDC PA Program
# APPLICATION FOR PROGRAM SELECTION

A one-time $25.00 application fee is required for each associate degree (A5 and AAS) program application submitted. All nursing options are considered one program. Payment must be made to the Bursar’s Office before the application can be processed.

<table>
<thead>
<tr>
<th>Last Name (Print)</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student Number</th>
<th>Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Apt#</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone Number:</th>
<th>Day Phone</th>
<th>Evening Phone</th>
<th>Alternate Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PREVIOUS EDUCATION:** LIST ALL INSTITUTIONS WITH DATES OF ATTENDANCE
(Official Transcripts must be evaluated by the College’s transcript evaluator)

Vocational School, College, University (Attach list if more than two)

<table>
<thead>
<tr>
<th>School Name</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Attendance Dates From Mo/Yr to Mo/Yr</th>
<th>Degrees or # of credits earned &amp; major</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Vocational School, College, University (Attach list if more than two)

<table>
<thead>
<tr>
<th>School Name</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Attendance Dates From Mo/Yr to Mo/Yr</th>
<th>Degrees or # of credits earned &amp; major</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PROGRAM FOR WHICH YOU ARE APPLYING:**

(See Reverse Side)

**TERM FOR WHICH YOU ARE APPLYING:**

Nursing Students Only: ___________ Fall (Aug-Dec) ___________ Spring (Jan-Apr) ___________ Summer (May-Jul) ___________ Year: ___________

Bridge Program Only: ___________ On-Line ___________ Face to Face

Do you hold a current license/certification in a health care field? Yes ___________ No ___________

If so, in what field is it?

**Note:** Clinical participation in some programs require students to be at least 18 years of age. All students are subject to a criminal background check. Please consult the program web page (www.mdc.edu/medical) for further information.

An applicant who has been convicted of a felony or the subject of arrest pertaining to a controlled substance should confer with an authorized representative of the regulatory/licensing agency to determine eligibility for future credentialing and practice. Graduates are subject to the laws, policies, and procedures of their respective regulatory/licensing board. The college cannot assure licensure/certification. Students are subject to the policies and procedures of affiliating agencies.

I certify all statements given in this application are true and accurate to the best of my knowledge. I agree to abide by the rules and regulations of Miami Dade College as published.

Applicant Signature ___________________________ Date of Submission ___________________________
# Programs Offered at Miami Dade College
## Medical Center Campus

Completed applications received by the due date will be given priority. Late applications will be considered on a space available basis.

<table>
<thead>
<tr>
<th>Program Starting Date: Application Due Date</th>
<th>Fall Term: May 1st</th>
<th>Spring Term: September 1st</th>
<th>Summer Term: February 15th</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Associate in Science Degree Programs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Hygiene</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Medical Sonography</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Information Management</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Histologic Technology</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Laboratory Technology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nursing Generic (Full Time)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Generic (Part Time)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Accelerated</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Nursing Advanced Placement (Transitional) (Full Time)</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Nursing Advanced Placement (Transitional) (Part Time)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opticiany</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Physical Therapist Assistant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Assistant Program (January 15th)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiation Therapy Technology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterinary Technology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Associate in Applied Sciences (AAS)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiography</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>College Credit Certificate Programs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Medical Technician (July 26; Nov.11; Mar. 15)</td>
<td></td>
<td>Jul. 26th</td>
<td>Nov. 11th</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paramedic (July 26; Nov.11; Mar. 15)</td>
<td></td>
<td>Jul. 26th</td>
<td>Nov. 11th</td>
</tr>
<tr>
<td>Healthcare Informatics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vocational Credit Certificate Programs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massage Therapy</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Medical Assisting</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Medical Coder/Biller Specialist</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Pharmacy Technician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phlebotomy Technician</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Practical Nursing</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Program application deadline is subject to change.
Applicants should refer to individual program information located on www.mdc.edu/medical for specific selection criteria. New students or continuing students who have not been enrolled at Miami Dade College during the last twelve-month period must also submit a college application. Submit all applications to:

Miami Dade College
Medical Center Campus
New Student Center
950 N.W. 20 Street
Miami, Fl. 33127

Miami Dade College is an equal access/equal opportunity institution and is in compliance with the American with Disabilities Act.
## Step Two

**Miami Dade College Physician Assistant Program Application**

- Program Application Transaction Record  
  Page 10
- Miami Dade College Physician Assistant Application  
  Pages 11-13
- Transfer Credit Review Form  
  Pages 14
- Health Care Experience Form  
  Pages 15-16
- Resume or Curriculum Vitae  
  Page 17
- Certification/Registration/Licensure Form  
  Page 18
- Reference List Form  
  Page 19
- Shadowing Experience Form  
  Page 20
A one-time non-refundable fee of $25 is required for each A.S. degree program to which the applicant is seeking admission. Applications will not be considered until this fee is paid in full.

Student Name (Print)  MDC Student Number

Address

Phone Number  Date

A $25 application fee is being paid for the following program(s):

_____ BAS with Physician Assistant Studies Option
_____ Bachelor’s Degree in Nursing N-5100
_____ Dental Hygiene-23022
_____ Diagnostic Medical Sonography-23039
_____ Health Information Management-23053
_____ Healthcare Informatics - 63014
_____ Histologic Technology-23063
_____ Medical Laboratory Technology-23023
_____ Nuclear Medicine- (AS Degree)-23069
_____ Nursing (all options)-23030
_____ Opticianry-23040
_____ Physical Therapy Assistant-23035
_____ **Physician Assistant-23060**
_____ Radiography-A3036
_____ Respiratory Therapy-23045
_____ Veterinary Technology-23062

________________________ TOTAL DUE  

AMOUNT PAID: __________________________

DATE PAID: __________________________

ACCOUNT #1009000-D19000-90-40503

RECEIPT #: __________________________

Applicant's signature  Cashier's signature

Note: Cashier must enter pre-select program code number in the first five characters of the description field of the miscellaneous receipt.
MIAMI DADE COLLEGE PHYSICIAN ASSISTANT PROGRAM APPLICATION

<table>
<thead>
<tr>
<th>Student Name (Print)</th>
<th>MDC Student Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Email #1</th>
<th>Email #2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Please answer all questions.*

**I. PERSONAL INFORMATION (Type or neatly print)**

Name: ____________________________  ____________________________  ____________________________

Last  First  M.I.

*If transcripts, test scores, or other documents are under another name, provide name:*

Date of Birth _____/______/______  Social Security Number: _____/______/______

**ADDRESS**

Number and Street: ____________________________  Apartment Number: ____________________________

City:  State:  Zip:  Country: ____________________________

Home Phone:  Cell Phone:  Alternate Phone: ____________________________

**II. CAMPUS RESEARCH DATA**

Please provide the following ethnic-race, gender and citizenship data which are required by Federal agencies. Miami Dade College is open to all regardless of sex, race, color, national origin, or handicap.

**Please Mark as follows:**

1. **Ethnic-Race Origin** - □ Non-Hispanic White  □ Non-Hispanic Black  □ Hispanic White
   □ Hispanic Black  □ American Indian or Alaskan Native  □ Asian or Pacific Islander
   □ Black or African American  □ Other (Specify) ____________________________

2. **Gender** - □ Female  □ Male

3. **Citizenship** - □ United States Citizen  □ Resident Alien  □ Refugee
   □ Visa Student (Specify) ____________________________

4. **Native Language** - □ English  □ Spanish  □ French  □ Creole
   □ Other (Specify) ____________________________
III. PROGRAM INTENTIONS AND MIAMI DADE COLLEGE ENROLLMENT STATUS

Program for which you are applying:  **Physician Assistant Program – 2306**

*Indicate the term for which you are applying:*

1. □Fall Term (Aug-Dec) □Spring Term (Jan – Apr) □Summer (May-July)

2. □Full-time □Part-time

*Miami Dade College Enrollment Status*

1. New Student (have not completed any courses at Miami Dade)

2. Continuing Student (enrolled at Miami Dade during the last 12 month period)

3. Former Student (have taken courses at Miami Dade but have not enrolled at Miami Dade during the last 12 month period.)

4. Other __________________________

*Have you previously been enrolled in a health care related program at Miami Dade College or another institution?*

1. □No  2. □Yes if yes, specify program and institution: __________________________

IV. PREVIOUS EDUCATION:  List all institutions with dates of attendance

*High School* (You must have official high school transcripts sent to Miami Dade College Admission office.)

<table>
<thead>
<tr>
<th>School Name</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Date Graduated or will Graduate (Mo./Yr.)</th>
</tr>
</thead>
</table>

*College, Universities:* (Attach list if attended more than two)

<table>
<thead>
<tr>
<th>School Name</th>
<th>City</th>
<th>State</th>
<th>Attendant Date From (Mo./Yr.) To (Mo./Yr.)</th>
<th>Degrees or Number of Credits earned</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>School Name</th>
<th>City</th>
<th>State</th>
<th>Attendant Date From (Mo./Yr.) To (Mo./Yr.)</th>
<th>Degrees or Number of Credits earned</th>
</tr>
</thead>
</table>
V. Are you currently employed in the healthcare field?

Explain

VI. CONDUCT

☐ Have you ever been convicted of anything other than a traffic violation?

1. ☐ No
2. ☐ Yes

If yes, please explain:

Have you ever been arrested and charged with a felony pertaining to controlled substances to which you entered a plea of nolo contendor, or for which you were adjudicated or adjudication was withheld because of placement in a pre-trial intervention program?

1. ☐ No
2. ☐ Yes

If yes, please explain:

VII. STATEMENT OF CERTIFICATION

I certify all statements given in this application are true and accurate to the best of my knowledge. I agree to abide by the rules and regulations of Miami Dade College as published. I also understand that the application and supporting documents are valid for two (2) year, that the application fee may not be waived nor is it refundable, and that the application and supporting documents become the property of Miami Dade College and cannot be returned.

Signature of Applicant

Date of Application
# TRANSFER CREDIT REVIEW FORM

I have submitted an application, application fee and have requested my transcripts. The following courses will transfer and meet the requirements of the Physician Assistant Program. This will be reviewed by a transcript evaluator.

<table>
<thead>
<tr>
<th>Requirement(s)</th>
<th>MDC Course #</th>
<th>College/University</th>
<th>Year</th>
<th>Equivalent Course #</th>
<th>Equivalent Course Title</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENC 1101</td>
<td>English Composition 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPC 1017</td>
<td>Fundamentals of Speech Communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLP 1006</td>
<td>The Psychology of Personal Effectiveness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHI 2604</td>
<td>Critical Thinking and Ethics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STA 2023</td>
<td>Statistical Methods</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BSC 2085</td>
<td>Human Anatomy and Physiology I</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BSC 2085L</td>
<td>Human Anatomy and Physiology I Lab</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BSC 2086</td>
<td>Human Anatomy and Physiology II</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BSC 2086L</td>
<td>Human Anatomy and Physiology II Lab</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHM 1033</td>
<td>Chemistry for Health Sciences</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHM 1033L</td>
<td>Chemistry for Health Sciences Lab</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCB 2010</td>
<td>Microbiology</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCB 2010L</td>
<td>Microbiology Lab</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HSC 0003</td>
<td>Intro. to Health Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CGS 1060</td>
<td>Intro. To Microcomputer Usage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** The above pre-requisite courses must be completed with a grade of “C” or better. All science courses taken more than five years ago must be repeated – Lecture only. Attach all “unofficial” transcripts to this page.
HEALTH CARE EXPERIENCE FORM
(Each form must be completed in full)

Student Name (Print) ___________________________ MDC Student Number ___________________________

List all health care experience, both paid and/or volunteer, beginning with your present position. (Please insert additional sheet(s) if needed.) PLEASE NOTE: Each applicant must also submit a resume or curriculum vitae (CV) listing, ALL employment and other work related history. Include information for at least the past ten years.

1. Position Title: ___________________________ From: _______________ To: _______________

Name & Address of Institution or Provider: __________________________________________________________

Telephone ___________________________ Supervisor/Title ___________________________

Type of Practice/Hospital Unit/Specialty ___________________________

Duties ________________________________________________________

Full Time ☐ Part Time ☐ Volunteer ☐ Paid ☐

Number of hours worked/volunteered per week ___________________________

Number of weeks worked per year ___________________________

Total number of years (round to nearest quarter) in position ___________________________

If less than one year, number of months in position ___________________________

Reason for leaving (if applicable) ___________________________

__________________________________________________________

2. Position Title: ___________________________ From: _______________ To: _______________

Name & Address of Institution or Provider: __________________________________________________________

Telephone ___________________________ Supervisor/Title ___________________________

Type of Practice/Hospital Unit/Specialty ___________________________

Duties ________________________________________________________

Full Time ☐ Part Time ☐ Volunteer ☐ Paid ☐

Number of hours worked/volunteered per week ___________________________

Number of weeks worked per year ___________________________

Total number of years (round to nearest quarter) in position ___________________________

If less than one year, number of months in position ___________________________

Reason for leaving (if applicable) ___________________________

__________________________________________________________
3. Position Title: ____________________________ From: ______________ To: ________________
Name & Address of Institution or Provider: ________________________________________________
____________________________________________________________________________________
Telephone ____________________________ Supervisor/Title ________________________________
Type of Practice/Hospital Unit/Specialty ________________________________________________
Duties ______________________________________________________________________________
__________________________________________________________
Full Time [ ] Part Time [ ] Volunteer [ ] Paid [ ]
Number of hours worked/volunteered per week ____________________________________________
Number of weeks worked per year ________________________________________________________
Total number of years (round to nearest quarter) in position ________________________________
If less than one year, number of months in position ________________________________________
Reason for leaving (if applicable) ________________________________________________________

4. Position Title: ____________________________ From: ______________ To: ________________
Name & Address of Institution or Provider: ________________________________________________
____________________________________________________________________________________
Telephone ____________________________ Supervisor/Title ________________________________
Type of Practice/Hospital Unit/Specialty ________________________________________________
Duties ______________________________________________________________________________
__________________________________________________________
Full Time [ ] Part Time [ ] Volunteer [ ] Paid [ ]
Number of hours worked/volunteered per week ____________________________________________
Number of weeks worked per year ________________________________________________________
Total number of years (round to nearest quarter) in position ________________________________
If less than one year, number of months in position ________________________________________
Reason for leaving (if applicable) ________________________________________________________

16
Resume
or
Curriculum Vitae

Each applicant must also submit Resume or Curriculum Vitae (CV) to the Physician Assistant Program
CERTIFICATION/REGISTRATION/LICENSURE
(Each form must be completed in full)

Student Name (Print)  MDC Student Number

☐ Do you have any professional Certifications?  No  Yes
☐ Do you have any professional Registrations?  No  Yes
☐ Do you have any professional Licensures?  No  Yes

Please list in the spaces provided any health related certifications, registrations or licensures. Attach copies of each certifications, registrations and/or licensures to this form.

Has your licensure/registration/certification ever been withdrawn or have been denied certification/registration/licensure?  No  Yes

If yes, please explain reason here: ____________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

1. Type of Cert./Lic./Reg.: _______________________ State: ___________ No: ______________________________
   Date Received: ___________________________ Expiration Date: ______________________________

2. Type of Cert./Lic./Reg.: _______________________ State: ___________ No: ______________________________
   Date Received: ___________________________ Expiration Date: ______________________________

3. Type of Cert./Lic./Reg.: _______________________ State: ___________ No: ______________________________
   Date Received: ___________________________ Expiration Date: ______________________________

4. Type of Cert./Lic./Reg.: _______________________ State: ___________ No: ______________________________
   Date Received: ___________________________ Expiration Date: ______________________________

A conviction may affect licensure. For additional information, please contact Department of Professional Regulation.

Licensure as a physician assistant may be affected by previous Licensure/registration/ certification denials or withdrawals.
REFERENCE LIST
(Three Letters of Recommendation)

Student Name (Print)                        MDC Student Number

Please list the individuals you have asked to provide a reference. The Letters of Recommendation must be on letterhead. We reserve the right to contact your references to verify authenticity.

While only (3) references are required, you may elect to ask more than four individuals to submit references on your behalf to insure that the program receives at least (3) by the deadline. (Use an additional page to list additional references if needed.)

1. Name:_________________________________________Title:_____________________
   Relationship to applicant: _________________________________________________
   Telephone Number: (____) __________________________________________________

2. Name:_________________________________________Title:_____________________
   Relationship to applicant: _________________________________________________
   Telephone Number: (____) __________________________________________________

3. Name:_________________________________________Title:_____________________
   Relationship to applicant: _________________________________________________
   Telephone Number: (____) __________________________________________________

4. Name:_________________________________________Title:_____________________
   Relationship to applicant: _________________________________________________
   Telephone Number: (____) __________________________________________________

THE LETTERS OF REFERENCE MUST BE PART OF THIS PACKAGE PRIOR TO SUBMISSION. THEY CAN’T BE FAXED, EMAILED, OR SENT VIA THE US MAIL.
SHADOWING EXPERIENCE FORM

To be completed by the Practitioner*

As a Miami Dade College physician assistant applicant, I understand that **50 hours of clinical and/or shadowing experience is highly recommended for all applicants without any healthcare experience.** Each separate experience should be documented on one form, so you will need to photocopy this form as necessary for additional experiences.

Applicant’s Name: ___________________________________________

Applicant’s Telephone Number ___________________ Applicant’s Email Address:

Clinical Setting:
  o Hospital
  o Private Office
  o Clinic
  o Other _______________________

Specialty________________________________________

Dates of Experience ____________________________ Estimated Hours of Experience __________________

**Supervising Practitioner Information**

Name: ____________________________

Phone Number: ___________________

Address: __________________________

Signature: _________________________

Please provide a brief description of supervising Practitioner’s duties and responsibilities witnessed by the applicant: ________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

*Can be PA, MD, DO, or NP