



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: _____

Student Signature: _____ Date: _____

To be Completed by PA

Signature of Supervising PA: _____ Date: _____

PA License Number: _____ State: _____

Leave blank, if unknown

* These hours are in preparation for application to Master of Physician's Assistant Programs. If there are any questions or concerns, please contact Career Development & Exploration at 216-687-2233 or careers@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.