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**Verification of Shadowing Hours**

*PLEASE COMPLETE THIS FORM IN ITS ENTIRETY.* Applicants must shadow with a licensed and practicing PA. This shadowing verification must be *completed* and *signed* by the licensed PA that was shadowed.

Applicant Name: \_\_\_\_\_

**Dates of Shadowing Experience**

<b>Date</b>	<b>Hours</b>	<b>Name of PA</b>

I/we hereby attest that the above named applicant has completed \_\_\_\_\_ hours of shadowing hours.

**Name of PA verifying shadowing hours:** \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Clinic/facility: \_\_\_\_\_

Address: \_\_\_\_\_

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*The above section must be completed for verification of shadowing hours.*