San Joaquin Valley College
Primary Care Physician Assistant Program
Supplemental Application Packet Checklist

(Please return this checklist with completed application packet)

Name (Please Print) _____SSN_____

Thank you for your interest in the SJVC Primary Care Physician Assistant Program. Please submit the following as **one packet** to the SJVC Primary Care Physician Assistant Program. Applicants are responsible for advising the PA program of address/telephone number changes.

- ❑ 1. Complete, sign and date the application. Falsification, omission, or misrepresentation will negate an application being reviewed or considered. Leave nothing blank—if an area does not apply to you, indicate N/A. Please *DO NOT* submit a resume or CV to substitute for, or be an addition to, any portion of the application.

- ❑ 2. Submit transcripts from all colleges/universities attended. Official sealed copies of transcripts must be submitted as part of the application packet. Foreign transcripts must be evaluated by a recognized evaluation agency, UC, CSU or California Community College and submitted as part of the application packet.

- ❑ 3. Submit PA program reference forms from two (2) individuals (physicians, physician assistants, nurses, supervisors, etc) familiar with your clinical experience. The reference forms must be signed and returned as part of the application packet. Reference forms must be placed in sealed envelopes which have been signed across the back flap by the evaluator.

- ❑ 4. I understand and have submitted the above information (including this checklist) or have indicated that an item does not apply to me.

I understand application materials become the property of the SJVC Primary Care Physician Assistant Program and the PA program reserves the right to verify any information related to my application submission.

Applicant Signature_____ Date_____

SJVC Primary Care PA Program Supplemental Application

Please type or print in black ink

1. **PERSONAL**

Name (last, first MI)_____

Other names used _____SSN_____

Date of Birth____/_____/_____ Place of Birth_____

Home Address:_____ City_____

County_____ State_____ Zip code_____

Home phone (____)_____ cell phone (____)_____

Current Employer:_____ Supervisor:_____

Address_____ Work phone(____)_____

2. **EDUCATION**

a)University/College _____

State_____ Country_____ Dates attended: from_____ to_____

Major _____ units completed (qtr)_____semester_____ GPA_____

Degree received: ❑AA/AS ❑ BA/BS ❑MA/MS ❑ MD ❑PhD ❑other_____

b)University/College _____

State_____ Country_____ Dates attended: from_____ to_____

Major _____ units completed (qtr)_____semester_____ GPA_____

Degree received: ❑AA/AS ❑ BA/BS ❑MA/MS ❑ MD ❑PhD ❑other_____

c) University/College _____

State_____ Country_____ Dates attended: from_____ to_____

Major _____ units completed (qtr)_____semester_____ GPA_____

Degree received: ❑AA/AS ❑ BA/BS ❑MA/MS ❑ MD ❑PhD ❑other_____

TOTAL UNITS COMPLETED (qtr)_____semester_____ Cumulative GPA_____

d) Vocational/Allied Health/Military corpsman school _____

Certificate/Military occupational specialty _____ year completed_____

3. **CLINICAL SKILLS** (*Please check item(s) which are or have been part of your job responsibilities)*

- ❑ medical history-taking
- ❑ physical examination
- ❑ vital signs
- ❑ first aid
- ❑ cardiopulmonary resuscitation
- ❑ EKG interpretation
- ❑ bacterial culture interpretation
- ❑ gastric lavage
- ❑ performing X rays
- ❑ injections
- ❑ catherization
- ❑ patient education
- ❑ physical therapy procedures
- ❑ splinting /casting
- ❑ suturing/suture removal
- ❑ O_2therapy/breathing tx
- ❑ intubation

Microscopic evaluation of:

- ❑ blood
- ❑ urine
- ❑ gram stained specimen
- ❑ Other clinical skills_____

4. **PAID/VOLUNTEER DIRECT PATIENT CARE EXPERIENCE.** Please list all clinical work. Attach a separate sheet if necessary. Tabulate total hours: e.g. 40 hrs/wk x 50 weeks = 2000 hours

a) Job Title_____ Employer_____

Supervisor_____ Phone (____)_____

Address _____
Street City State Zip

Total hours_____ from _____ to _____

Description of duties _____

_____

_____

b) Job Title_____ Employer _____

Supervisor_____ Phone (____)_____

Address _____
Street City State Zip

Total hours_____ from _____ to _____

Description of duties _____

_____

_____

4. **PAID/VOLUNTEER DIRECT PATIENT CARE EXPERIENCE.** Please list all clinical work. Attach a separate sheet if necessary. Tabulate total hours: e.g. 40 hrs/wk x 50 weeks = 2000 hours

c) Job Title_____ Employer _____

Supervisor_____ Phone (____)_____

Address _____
Street City State Zip

Total hours_____ from _____ to _____

Description of duties _____

_____

_____

MILITARY SERVICE

d) Job title_____ from _____ to _____

e) Job title_____ from _____ to _____

f) Discharge date_____ ***please submit copy of DD 214***

5. **CURRENT LICENSE/CERTIFICATON**

g) License/certification _____ State where issued_____

Date issued _____Date expires_____

h) License/certification_____ State where issued_____

Date issued_____Date expires_____

i) License/certification_____ State where issued_____

Date issued_____Date expires_____

j) License/certification_____ State where issued_____

Date issued _____Date expires_____

6. **PREREQUISITE COURSEWORK**: Please list all *completed* prerequisites below. *Do not* list courses in progress. If you are not sure that the course submitted meets prerequisites please submit college course description, for evaluation, with your application.

Prerequisites	College or Univ.	Department Name Course Number and Complete Course Title	Sem./ Qtr. Units	Year & Term Taken	Final Grade
Human Anatomy					
Human Anatomy Lab					
Human Physiology					
Human Physiology Lab					
General Microbiology					
General Microbiology Lab					
General Chemistry					
General Chemistry Lab					
General Psychology					
Intro to Sociology or Cultural Anthropology					
Reading and Composition					
Public Speaking or Oral Communication					
Intermediate Algebra (or Higher)					

7. **CHARACTER AND FITNESS FOR LICENSURE:** Please note that conviction of a criminal offense or professional disciplinary actions may prevent PA licensure in the state of California.

a) Have you ever been enrolled in any other PA Program? ❑ Yes ❑ No

b) Have you ever been convicted of a crime? ❑ Yes ❑ No

c) Have you ever been disciplined, placed on academic probation, or dismissed in connection with your academic performance? ❑ Yes ❑ No

d) Have you ever been: disciplined, sanctioned, placed on probation, received a suspended or revoked professional license or certification? ❑ Yes ❑ No

e) Is there pending disciplinary judgment/action against you in connection with any legal, educational, professional, military, or employment matters? ❑ Yes ❑ No

If you answered yes to any of the questions above, please provide a complete and detailed explanation in the space below. Please contact the Physician Assistant Committee of the Medical Board of California concerning specific questions you may have about licensure.

8**. PREFERENCE:** Additional ranking points, for determining granting of an admission interview, may be given to those with a "demonstrated commitment to working in underserved communities." Criteria for receiving these points include: working, residing or providing community services in underserved communities. Please list all community service experience/activities below. You may attach additional sheets if necessary.

Activity_____

Role/Responsibilities_____

_____

Date(s)_____

Contact _____

Organization Contact Person

_____

Address Phone

Activity_____

Role/Responsibilities_____

_____

Date(s)_____

Contact _____

Organization Contact Person

_____

Address Phone

Please describe below, any other reason(s) you should receive preference points for "Demonstrated commitment to working in underserved communities."

_____

_____

_____

_____

9. **CERTIFICATION**

I certify that all responses to the questions and any information given herein are my own for the purpose of determining admissions.

I consent to and authorize any educational institution I have attended to release any academic and/or disciplinary information to the SJVC PA Program.

I understand that information submitted relative to this application becomes property of the SJVC PA Program.

I further understand that the SJVC PA Program reserves the right to verify any or all information which I or others have provided whether solicited by me or not.

Applicant Signature_____ Date_____

The SJVC Primary Care PA program complies with Titles VI and VII of the Civil Rights act of 1994, Title IX of the Education Amendment of 1972, Section 503 and 504 of the rehabilitation Act of 1973, Sections 102 and 103 of the American with Disabilities Act of 1990. The PA program does not discriminate on the basis of race, color, national origin, religion, handicap, or sexual orientation in any of our policies, procedures or practices.

OPTIONAL: The following information is collected for federal, state and accreditation agencies reporting purposes only. Your cooperation in providing the information is greatly appreciated. Completing this section will not affect your application for enrollment to the SJVC PA program, and is maintained in confidence. Please check the appropriate boxes:

❑ Male ❑ Female

❑American/Alaskan Native (Tribal affiliation)_____
❑ Asian/Pacific Islander
❑African American/Black
❑Caucasian
❑Hispanic/Latino
❑ Other_____

San Joaquin Valley College
Primary Care Physician Assistant Program
Applicant Reference Form

Dear Evaluator:

Please return this reference form directly to the applicant in a sealed envelope with your signature across the seal. The applicant will then *include the sealed envelope with his/her application packet* to the SJVC Primary Care Physician Assistant Program. **Please do not mail the reference form directly to the PA program, this may impede processing of the application or cause the application to be considered incomplete at time of review.**

Because of federal law giving students access to educational records, the SJVC Primary PA program cannot guarantee the confidentiality of your comments unless the applicant has signed the waiver of applicant right to access below.

Thank you for your cooperation,
Admissions Committee
SJVC Primary Care Physician Assistant Program

Instructions: Information to be completed by Applicant

Waiver of Applicant Right to Access

I hereby freely and voluntarily waive my right to access to information contained on this evaluation form and agree that the statements shall remain confidential.

Applicant signature_____ Date_____

Applicant Name_____
Last First M.I.

Applicant's last four SSN_____

Applicant's address: _____
Street City State zip code

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Instructions: Information to be completed by Evaluator If the applicant has waived his/her right to access to materials (see above), this document remains a confidential communication between the evaluator and the SJVC PA program.

Relationship to applicant: ❑ Employer ❑ Supervisor ❑ Faculty ❑ Other
How long have you known the applicant? From_____to_____

Please comment on the strengths and weaknesses of the candidate according to your knowledge of him/her in the following areas:

Maturity: _____

Emotional Stability in stressful situations: _____

Ability to learn new information: _____

Interpersonal skills: _____

Clinical Skills:_____

Additional Comments:_____

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Applicant Reference Form

Instructions: Information to be completed by Evaluator Please check one of the following recommendations.

Applicant has my highest recommendation ❑

I recommend the applicant with confidence ❑

I recommend the applicant with some reservations ❑

I do not recommend the applicant ❑

May a program representative contact you for additional information? ❑ Yes ❑ No

Daytime telephone number(s)_____

Signature _____ Date_____

Please Print Name_____

Title_____

Institution/Facility _____

Address _____

Thank you for your participation in the SJVC Primary Care Physician Assistant Program Admission process. If you have any questions concerning this form, please contact the PA program at (559)651-2500 X173.

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