

# LMU | School of Medical Sciences

LINCOLN MEMORIAL UNIVERSITY

## Knoxville Physician Assistant Program Supplemental Application

Date of Application: \_\_\_\_\_ LMU ID # (if applicable): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_  
                                 Last                                  First                                  Middle                                  Preferred

Mailing Address: \_\_\_\_\_  
                                 Street                                  City                                  State                                  Zip Code

Phone (cell/home): \_\_\_\_\_ Email address: \_\_\_\_\_

Permanent Residence: \_\_\_\_\_  
   City    State    County

*Consistent with the mission of Lincoln Memorial University, applicants with permanent residence in the Appalachian region of TN, KY, VA, NC, OH, WV, PA, AL, and GA are given preference. This preference is applied with a 3-tiered system. Greatest preference is given to applicants with permanent residence in the Appalachian region of Tennessee. Applicants with permanent residence in the Appalachian region of KY, VA, NC and WV are given greater preference than applicants with permanent residence in the Appalachian region of OH, PA, AL and GA.*

### HEALTH CARE/SHADOWING EXPERIENCE

Please indicate on the chart below the status of your health care/shadowing experiences. In the “Experience Type” column, select the experience type from the dropdown menu. In the “Clinical Site / Provider” column, list the name of the health care facility for director and partial patient care or the name and title (e.g. PA, MD, DO) of the provider shadowed. In the “Total Hours” column, list the number of hours spent either providing patient care or shadowing. In the “Date(s)” column, list the dates of each experience. If you have not completed your health care/shadowing experience hours, type “pending” in each applicable space. *Preference* is given to applicants with more than one type of patient care experience (each setting must have a minimum of 24 hours to qualify as a different type).

Experience Type	Clinical Site / Provider	Total Hours	Date

### CERTIFICATION

I have reviewed and understand the CASPA Applicant Responsibilities, Professional Code of Conduct, and Violation of Code of Conduct Policy. I pledge to act in accordance with CASPA’s defined set of guidelines for applicant responsibilities, expected standards of performance, and behavior.

[https://help.liasonedu.com/CASPA\\_Applicant\\_Help\\_Center/Starting\\_Your\\_CASPA\\_Application/Getting\\_Started\\_with\\_Your\\_CASPA\\_Application/4\\_CASPA\\_Professional\\_Code\\_of\\_Conduct](https://help.liasonedu.com/CASPA_Applicant_Help_Center/Starting_Your_CASPA_Application/Getting_Started_with_Your_CASPA_Application/4_CASPA_Professional_Code_of_Conduct)

I certify that all information provided on this application is true, accurate, and complete to the best of my knowledge and belief, and is made in good faith. I also certify that the responses to the questions on page 3 of this supplemental application are my own work. I know and understand that any and all items contained herein are subject to verification and I consent to the full release of all information concerning my capacity and fitness for the educational program by employers, educational institutions and other agencies. I know that failure to provide true, accurate, and complete information can result in rescinding of an admission offer or, if admission is offered and accepted, dismissal from the program.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Submit a saved copy of your application to [PAKnox@LMU.net](mailto:PAKnox@LMU.net).

Questions: 800.325.0900 ext. 5685 or [PAKnox@LMU.net](mailto:PAKnox@LMU.net)