RECOMMENDATION FORM

SCHOOL OF HEALTH RELATED PROFESSIONS
University of Medicine & Dentistry of New Jersey

University of Medicine and Dentistry of New Jersey

Physician Assistant Program

I. **TO THE APPLICANT**: Please complete the upper portion of this Recommendation Form before forwarding it to the individual who is recommending you.

Name of Applicant ______________________ Address of Applicant ______________________

NOTICE TO WRITER OF STATEMENT AND APPLICANT: Public Law 93 - 380, Educational Amendments Act of 1974, grants students and graduates the right of access to Letters of Recommendation in their student files. The opportunity to waive one's right to inspect such letters is also provided by the law. Please indicate your wish by completing and signing the statement below. **Your right to review this form is considered waived if you do not indicate a response.**

I, the undersigned, hereby (☐ do, ☐ do not) waive my right of access to this Letter of Recommendation.

Signature of Applicant ______________________ Date ______________________

II. **TO THE PERSON COMPLETING THE RECOMMENDATION FORM:** Please fill out the remaining portion of this questionnaire and return it promptly.

Writer of Recommendation (please print) ______________________

A. Please rate the applicant in regard to the following characteristics. (5 = highest rating; 1 = lowest rating)

CHARACTERISTICS	RATING					
	5	4	3	2	1	Cannot Evaluate
Natural Intellectual Ability						
Breadth of General Knowledge						
Ability to Express Self in Written English						
Ability to Express Self in Oral English						
Analytical Ability						
Emotional Maturity						
Ability to Work with Others						
Performance of Required Tasks						
Promise as a Health Care Provider						
Leadership Ability						
Honesty						

(over)

B. How long have you known the applicant and in what capacity?

C. In what respect does the applicant impress you most favorably?

D. In what respect does the applicant impress you least favorably?

E. Please make any additional comments about the applicant's record, potential or personal qualities which you feel would be helpful to the Admissions Committee. We are especially interested in anything that would not be otherwise apparent in the candidate's record.

F. Overall Evaluation:

- ❑ I recommend this applicant **without reservation**
- ❑ I recommend this applicant
- ❑ I recommend this applicant **with reservations**
- ❑ **I would not recommend** this applicant

Date	Signature	Title
	Address	Telephone Number

Return this Letter of Recommendation to the applicant in a sealed envelope. Sign across the seal to maintain confidentiality.

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RECOMMENDATION FORM

UMDNJ

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University of Medicine & Dentistry of New Jersey

University of Medicine and Dentistry of New Jersey

Physician Assistant Program

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