

ST. ELIZABETH MEDICAL CENTER
SCHOOL OF RADIOGRAPHY

2209 Genesee Street, Utica, New York 13501 (315)798-8258

LETTER OF RECOMMENDATION FORM

Name of Applicant: _____

(Please note that letters from personal friends and relatives are NOT acceptable)

APPLICANT: PLEASE COMPLETE THIS SECTION BEFORE SUBMITTING THIS FORM FOR REFERENCE:

In accordance with the provisions of the Family Educational Rights and Privacy Act of 1974, P.L. 93-390 (as amended) , with specific reference to Section 438 (a) (1) (B) and Subtitle A, sections 99.7 , 99.11 and 99.12

DO _____ waive my right of access to review this letter of reference I am requesting.

DO NOT _____ I may review the recommendation after I have matriculated as a student at St. Elizabeth Medical Center, School of Diagnostic Radiography.

Signature of Student

Date

TO THE INDIVIDUAL GIVING THE REFERENCE:

_____ has applied for admission into St. Elizabeth Medical Center, School of Radiography.

The candidate and the School would appreciate if you would take a few minutes of your time to complete this evaluation .

Your input is valuable to us, as it will aid us in determining the suitability of the candidate for this program.

Note: The candidate has either waived His/her right to the content of this recommendation. Be aware that this material will remain confidential, if the student has not waived their right to access.

1. How long have you known this candidate? _____

2. In what capacity have you known this candidate ? _____

3. PERSONAL APPRAISAL: (PLEASE CHECK THE CATEGORY WHICH BEST INDICATES YOUR EVALUATION OF THIS CANDIDATE IN TERMS OF THE LISTED CHARACTERISTICS.)

Characteristics	Superior	Above Average	Average	Below Average	No Basis for Evaluation
A. Academic Potential					
B. Leadership					
C. Sense of Responsibility					
D. Ability to Work with People					
E. Ability to Adapt to New Situations					
F. Ability to Work Independently					
G. Reliability					
H. Verbal Communication Skills					
I. Written Communication Skills					
J. Attendance Record					
K. Ability to Analyze Problems and Solve them Effectively					

FOLLOWING TO BE COMPLETED ONLY IF EMPLOYEE IS IN A HEALTH CARE FACILITY

1. Professional Competency					
2. Professional Appearance					
3. Rapport with Patients					

Recommendation for Acceptance:

_____ Strongly recommended _____ Recommended

_____ Recommended with reservations _____ Do Not Recommend

COMMENTS. (Separate paper may be used) Please give a brief description of this candidate as you have observed them. How may they benefit our Program?

PLEASE TYPE OR PRINT

Your Name _____

Title: _____

Organization: _____

Address: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Date: _____ Signature: _____

We thank you for your time to complete this form, it is appreciated.

Please Return To:

Program Director
St. Elizabeth Medical Center
School of Radiography
2209 Genesee St.
Utica, New York 13501