RECOMMENDATION REQUEST FORM FOR APPLICANT

TO BE COMPLETED BY APPLICANT (Print or type this section only)

Name of Applicant:

First Name Middle Initial Last Name

Street Address or P.O. Box

City State Zip Code Telephone No.

Signature of Applicant

(To be completed by person completing references)

PLEASE COMPLETE AND RETURN THIS FORM TO:

Englewood Hospital and Medical Center
School of Radiography
350 Engle St.
Englewood, N.J. 07631
Attn: Admissions Office

I have known the applicant for approximately _____ (months/years).
My relationship to the applicant was (or is) in the following capacity.

_____ Guidance counselor _____ Employer _____ Teacher

_____ Supervisor _____ Minister _____ Other

If other, please specify _____

I know the applicant:

_____ Very well _____ Fairly well _____ Only casually

PLACE AN x UNDER THE COLUMN WHICH BEST DESCRIBES THE APPLICANT

Characteristics Evaluated	Excellent	Above avg.	Avg.	Unsatisfactory	N/A
Academic Ability	☐	☐	☐	☐	☐
Writing Skills	☐	☐	☐	☐	☐
Oral Communication Skills	☐	☐	☐	☐	☐
Leadership Skills	☐	☐	☐	☐	☐
Initiative & Motivation	☐	☐	☐	☐	☐
Assertiveness	☐	☐	☐	☐	☐
Cooperativeness	☐	☐	☐	☐	☐
Relating to Supervisors	☐	☐	☐	☐	☐
Relating to Peers	☐	☐	☐	☐	☐
Dependability	☐	☐	☐	☐	☐
Accepts Criticism	☐	☐	☐	☐	☐
Personal Appearance	☐	☐	☐	☐	☐

Does the applicant demonstrate any weakness or deficiencies which you feel would hinder his/her ability to perform as a student in our program? _____ Yes _____No If yes, please explain:

Other Comments: _____

_____

_____

Recommendation concerning admission (check one).

_____ I highly recommend this applicant _____ I recommend this applicant

_____ I am not able to recommend this applicant

_____

Signature of Recommender Date

_____

Name (typed or printed)

_____

Street Address or P.O. Box

_____

City State Zip code Telephone No.

If you have any further comments or questions, please feel free to contact
Englewood Hospital and Medical Center School of Radiography at (201) 894-3481.