University of Minnesota Medical Center, Fairview
School of Radiation Therapy
Recommendation Form

Applicant Information & Waiver – *to be completed by student applicant*

Name of Applicant-*list first name, middle, maiden name, last name*	
Type of Program	Name of Program
I hereby waive any rights I may have to this recommendation form when completed. In addition, I understand that this confidential recommendation is to be used only in consideration of my application to University of Minnesota Medical Center, Fairview School of Radiation Therapy..	
Signature of Applicant **X**	Date of Signature

Recommendation – *to be completed by recommender*

The applicant named above is applying to University of Minnesota Medical Center, Fairview radiation therapy program. As class sizes are limited, it is our responsibility to select students whose abilities, motives, and character give the greatest promise of success. Therefore, we ask you to provide thoughtful and candid responses to this inquiry.

School administration and the Admissions Committee will use the information you furnish. You may wish to send a personal letter in addition to the format provided here; **however, we request that you complete this form regarding the applicant's personal characteristics.** Your evaluation will not be shared with the applicant. Due to the large number of applications, accompanying endorsements and references involved, we do not routinely send acknowledgements of references. We are grateful for your assistance.

To ensure validity, off-line recommendation forms must be returned in a sealed envelope with your signature across the sealed flap.
Thank you.

Name of Recommender – first, middle, last			Date Form Completed
Place of Employment			Position
Address			Phone
City	State	Zip	E-mail address
How long have you known or observed this applicant?			

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MEDICAL CENTER
FAIRVIEW

Recommendation Continued- *to be completed by recommender*

What is your relationship to the applicant? ☐ Advisor ☐ Teacher ☐ Work Supervisor ☐ Other Specify:
What characteristics do you consider to be the principal strengths and talents of the applicant?
In What areas, if any can the applicant make improvements?

On a scale of 1 to 5 (with 5 being the highest ranking) select the box, which best represents your knowledge or observation regarding each of the following characteristics or abilities. Provide any additional comments in the spaces provided.

Ability to apply critical thinking and problem solving	Below Avg ☐ 1	☐ 2	☐ 3	☐ 4	Exceptional ☐ 5	NA ☐
Ability to give and receive feedback (acceptance of criticism)	Below Avg ☐ 1	☐ 2	☐ 3	☐ 4	Exceptional ☐ 5	NA ☐
Ability to work with others (teamwork)	Below Avg ☐ 1	☐ 2	☐ 3	☐ 4	Exceptional ☐ 5	NA ☐
Attendance and punctuality	Below Avg ☐ 1	☐ 2	☐ 3	☐ 4	Exceptional ☐ 5	NA ☐
Communication skills (written and verbal)	Below Avg ☐ 1	☐ 2	☐ 3	☐ 4	Exceptional ☐ 5	NA ☐
Flexibility and adaptability	Below Avg ☐ 1	☐ 2	☐ 3	☐ 4	Exceptional ☐ 5	NA ☐
Organizational skills	Below Avg ☐ 1	☐ 2	☐ 3	☐ 4	Exceptional ☐ 5	NA ☐
Personal appearance	Below Avg ☐ 1	☐ 2	☐ 3	☐ 4	Exceptional ☐ 5	NA ☐
Self-confidence (emotional and social maturity)	Below Avg ☐ 1	☐ 2	☐ 3	☐ 4	Exceptional ☐ 5	NA ☐
Work performance and motivation to complete work assignments	Below Avg ☐ 1	☐ 2	☐ 3	☐ 4	Exceptional ☐ 5	NA ☐

Recommendation Continued- *to be completed by recommender*

Overall rate of applicant as a prospective health-care professional	Below Avg ☐ 1	☐ 2	☐ 3	☐ 4	Exceptional ☐ 5	NA ☐
Comments:						
May we contact you with questions regarding this applicant?	☐ Yes	☐ No				

Signature of Recommender	Date
X	

Recommender: Please return completed recommendation in a sealed envelope with your signature across the sealed flap on the back of the envelope. Mail to: University of Minnesota Medical Center, Fairview, School of Radiation Therapy, MMC 400, 420 Delaware St. SE, Minneapolis, MN 55455.

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