

Professional Reference Form

The Firelands Regional Medical Center School of Nursing does not discriminate on the basis of race, color, religion, ancestry, ethnicity, gender/transgender status, gender identity, sexual orientation, age, national origin, marital status, disability, pregnancy, parental status, military and/or veteran status, genetic information, or other characteristics protected by the law.

The applicant named below is a candidate for admission to this School of Nursing. We would appreciate your evaluation of the applicant's performance and potential. Your comments will be used by the Admissions Committee of this School of Nursing to help arrive at a better understanding of the applicant. Your cooperation in completing and promptly returning this form will assist both the applicant and the School of Nursing. Thank you for your time.

Applicant Name: _____
(Last Name) (First Name) (Middle Initial)

Address: _____
(Number and Street)

(City) (State) (Zip Code)

Pursuant to recent federal law, a student admitted to this School of Nursing is entitled to inspect this evaluation in his or her file, unless the student has signed a waiver of this right of access. However, the School does not require a waiver as a condition for admission to, receipt of financial aid from or receipt of any other services or benefits from the School. Applicants submitting names of individuals for letters of recommendation; therefore, are free to determine whether or not they wish to waive their potential right to examine such evaluations.

WAIVER

The Family Educational Rights and Privacy Act permits us to request, but not require, that you waive your right to inspect this evaluation. The right, which we request that you waive, would arise if you were an enrolled student at this school and if the evaluation were maintained after your enrollment. In considering whether you will waive, please be advised that the information contained on this form will be used to evaluate you as an applicant for admission to this School of Nursing. *If you elect to waive your rights of access to and review of this information, please sign your name.*

(Date)

(Applicant Signature)

References completed by friends and family members WILL NOT be accepted.

Applicant Name: _____

Length of time you have known applicant and in what capacity:

Professional Qualities Noted: (Please explain below how these qualities do or do not apply to the applicant.)

Initiative:

Personality:

Willingness to accept responsibility:

Attitude:

Perseverance:

Interpersonal relationships:

Punctuality:

Clinical skills (if applicable):

Identify strengths in this applicant that would make him/her/them a desirable candidate for professional nursing:

Identify opportunities for improvement in this applicant that would assist the school in guiding his/her/their development as a professional nurse:

Identify experiences or activities that may have influenced the development of this applicant:

Please indicate whether or not you endorse the applicant as a suitable candidate for professional nursing.

Endorse

Do Not Endorse

Reason:

If the applicant's signature appears at the end of the paragraph identified as "waiver" on the reverse side of this form, you can be assured that your evaluation will not be reviewed by the applicant. If the applicant has not signed the waiver and enrolls at this School, the applicant will have the right to review your evaluation.

Date: _____

Printed Name: _____ Signature: _____

Title or Position: _____ Institution: _____

Phone: _____ Email: _____