**Non-Faculty Recommendation Form**

**MATRICULATE CLASS 2020**

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| **PLEASE RETURN YOUR SIGNED RECOMMENDATION ON LETTERHEAD ALONG WITH THIS FORM BY** **MARCH 1, 2019** **TO: Lafayette College, Health Professions Office, 101 Scott Hall, 714 Sullivan Road, Easton, PA 18042. OR SEND AS PDF ATTACHMENT TO Ms. Emrick via email at** **healthprofessions@lafayette.edu**. |

**APPLICANT:** Please enter all information in this section.

|  |  |
| --- | --- |
| **Recommender’s Name**: | **Institution**: |
| **Applicant’s Name**: | **Student Number**: |
| **Class Year**: | **Degree Program**: |
| **Major(s)/ Minor**: | **Cumulative GPA**: |

**WAIVER OF RIGHTS:**

Waiver of Access: I understand that Federal law (Family Educational Rights and Privacy Act of 1974) provides me with a right of access to this recommendation and that no school may require me to waive this right.

I hereby  **waive** my right of access to this recommendation.

**do not waive** my right of access to this recommendation.

|  |  |  |
| --- | --- | --- |
| Applicant’s Signature: |  | Date: |

**RECOMMENDER:** **Please enter all information in this section.**

I,     , understand that my letter will form part of the applicant’s Health Professions Advisory Committee letter sent to health professions schools. I also understand that my letter will be included verbatim, along with my name and professional identification, with other letters solicited by the applicant.

|  |  |  |
| --- | --- | --- |
| Recommender’s Signature: |  | Date: |

As part of your evaluation, please check the appropriate category below**.**

***VERY HIGHLY RECOMMEND:*** Applicant has demonstrated evidence of exceptionally outstanding potential.

***HIGHLY RECOMMEND:*** Applicant has exhibited abilities/qualities well above those of average applicant.

***RECOMMEND:*** Applicant has demonstrated potential for successful completion of health professions training.

***RECOMMEND WITH RESERVATION:*** Applicant has exhibited potential, but some aspects cause concern.

***NOT RECOMMEND:*** Applicant lacks demonstrable evidence of qualities to complete health professions training.

***NOT ABLE TO EVALUATE USING THIS SCALE’S CRITERIA***.

In your letter of recommendation please explain your relationship to the applicant with reference to how you know him/her and in what capacity you have interacted. Please provide reasons and details to support and contextualize your overall evaluation. Of particular help are comments on any of the following applicable qualities sought by health professional schools among their applicants:

**Interpersonal Competencies** (service focus, social and cultural skills, teamwork, oral communication), **Intrapersonal Competencies** (reliability, resiliency, capacity to improve, ethically sensitive), **Thinking and Reasoning Competencies** (critical thinking, quantitative reasoning and inquiry, written communication), **Science Competencies** (living systems, human behavior).

To assist us in our holistic evaluation, please complete the rating form below, providing the context of the group with whom you are comparing the applicant.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Applicant Exhibits Traits*** | ***Top***  ***2%*** | ***2% -***  ***10%*** | ***10%-***  ***25%*** | ***25%-***  ***50%*** | ***50%-***  ***60%*** | ***60% or***  ***below*** | ***Unable***  ***To rank*** |
| Maturity |  |  |  |  |  |  |  |
| Self-reflection |  |  |  |  |  |  |  |
| Motivation |  |  |  |  |  |  |  |
| Persistence |  |  |  |  |  |  |  |
| Integrity |  |  |  |  |  |  |  |
| Creativity |  |  |  |  |  |  |  |
| Judgment |  |  |  |  |  |  |  |
| Leadership Capacity |  |  |  |  |  |  |  |
| Ability to Collaborate |  |  |  |  |  |  |  |
| Compassion |  |  |  |  |  |  |  |
| Emotional Intelligence |  |  |  |  |  |  |  |
| Cultural Sensitivity |  |  |  |  |  |  |  |
| Effective Communication |  |  |  |  |  |  |  |
| Realistic Awareness of Professional Expectations |  |  |  |  |  |  |  |
| Evidence of relevant technical skills |  |  |  |  |  |  |  |
| ***Comparative group:*** | | | | | | | |

Your Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for your time and assistance!

Lafayette College Health Professions Advising Team