



TO BE FILLED OUT BY THE APPLICANT

Statement of confidentiality of recommendation

(To be completed by the applicant.)

Federal law grants students the right to view letters of reference or have the contents disclosed to them after acceptance. If you, the applicant, agree to waive this right, then you will not have access to this reference. If you do not agree to waive this right, then you will have access to this reference.

- I waive my right to this reference.
I do not waive my right to this reference.

Applicant's Name (please print or type):

Applicant's Signature:

TO BE FILLED OUT BY THE RECOMMENDER:

Name (please print or type):

Title and affiliation:

Address:

City:

State:

ZIP code:

Phone (w/area code):

Email:

How well to you know the applicant? Very well Moderately Slightly

How long have you known the applicant?

My relationship to the applicant was (is) in the following capacity:

- High School teacher High School science teacher High School Counselor College Instructor

Other (please specify):

## CHARACTERISTICS

How do you rate the applicant on each of the following characteristics? Please check the box which best describes the applicant.

Characteristic	Outstanding	Good	Fair	Poor	No basis for judgment
Intellectual ability	<input type="checkbox"/>				
Industry (perseverance, works hard, endurance)	<input type="checkbox"/>				
Initiative (independent, self-starter, motivated)	<input type="checkbox"/>				
Dependable	<input type="checkbox"/>				
Integrity (honesty, morally consistent)	<input type="checkbox"/>				
Critical thinking	<input type="checkbox"/>				
Maturity (leadership, dependability, sense of direction)	<input type="checkbox"/>				
Judgment (common sense, decisiveness)	<input type="checkbox"/>				
Potential to be a successful physician	<input type="checkbox"/>				
Understanding of scientific process	<input type="checkbox"/>				
Written expression	<input type="checkbox"/>				
Oral expression	<input type="checkbox"/>				

## REFERENCE

Optional: Please elaborate on any of the above characteristics that you deem relevant to his/her character, capabilities and performance in this program in a separate letter.

Please either scan/email your completed recommendation to [holt\\_daniell@columbusstate.edu](mailto:holt_daniell@columbusstate.edu) (subject line "CPSP recommendation") or mail to

Dr. Daniel Holt  
 CSU Competitive Premedical Studies Program  
 4225 University Ave.  
 Columbus, GA 31907

Application deadline: February 15th

Your recommendation will become part of the applicant's file and used to determine admittance into the CSU Competitive Premedical Studies program. The disclosure of the contents of this document cannot be guaranteed unless the statement which waives access has been signed by the applicant. Thank you for taking the time to complete this application.

## OVERALL RECOMMENDATION

Please provide your overall recommendation of the candidate for admission into the Competitive Premedical Program (*please check one*):

- |  |  |
|--|--|
| <input type="checkbox"/> I highly recommend this applicant                     | <input type="checkbox"/> I recommend this applicant        |
| <input type="checkbox"/> I recommend this applicant but with some reservations | <input type="checkbox"/> I do not recommend this applicant |

Signature of recommender:

Date: