



RECOMMENDATION REQUEST MANAGED CARE PHARMACY PRACTICE RESIDENCY PROGRAM

To be completed by applicant:

(Please print or type)

Name of Applicant:

First Name
M.I.
Last Name

 Street address or P.O. Box

City
State
Zip
Telephone Number

I waive the right to review this recommendation. _____
Signature of Applicant

Applicants to the residency program specified above are required to have recommendations submitted by persons who are in a position to evaluate their qualifications for residency training. The recommender is asked to make a frank appraisal of the applicant's character, personality, abilities, and suitability for a pharmacy residency. **All comments and information provided will be kept in strictest confidence.**

For the recommender to complete:

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

- Faculty advisor clerkship preceptor other faculty relationship other (please specify) _____

I know him/her: very well fairly well only casually

Relative to persons of **similar background, training, and professional interests**, how would you rate this applicant for each of the following characteristics? Please indicate what number (_____) of students or employees you have precepted or supervised over the past 2 years that you are using as a comparison group. Please place an **X** under the rating column which best describes the applicant.

CHARACTERISTICS EVALUATED	UPPER 10%	UPPER 25%	UPPER 50%	LOWER 50%	NO BASIS FOR JUDGMENT if marked please comment
Quality of work					
Written communication skills					
Oral communication skills					
Leadership skills					
Industriousness and perseverance					
Initiative and motivation					
Assertiveness					
Cooperativeness					
Ability to organize and manage time					
Ability to work with supervisors					
Ability to work with peers					
Ability to work with patients					
Dependability					
Resourcefulness and originality					
Willingness to accept constructive criticism					
Personal appearance and professional demeanor					
Commitment to professional practice					
Emotional stability and maturity					
Enthusiasm					
Integrity					

(continued on reverse)

Please attach to this evaluation form, a letter of recommendation that addresses, as a minimum, the following items:

- Does the applicant possess any special assets that should be noted? Please describe a situation or activity that best exemplifies the asset/s mentioned.
- Does the applicant demonstrate any weakness that you feel would hinder his/her ability to perform effectively in a residency program? Please describe the situation or activity that best exemplifies the weakness/es.
- Please comment on the applicant's ability to engage in project or research activities.

Recommendation concerning admission (**check one**)

I highly recommend this applicant.

I recommend this applicant, but with some reservation.

I recommend this applicant.

I am not able to recommend this applicant.

Signature of Recommender

Date

Name -- typed or printed

Title and affiliation

Street address or P.O. Box

City

State

Zip

Telephone

email address

Please complete and return this form no later than January 8th 2010 to:

Jim Carlson, Pharm.D.
Director, Pharmacy Clinical and Health Plan Services
Director, Residency Program
Group Health Pharmacy Administration
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