

RECOMMENDATION FORM

Hampton University School of Pharmacy

Two recommendations using this form are required with each application. Recommendations must come from a math professor, a science professor, or a pharmacist. **Letters submitted in lieu of this form will not be accepted.** Recommenders are to send this completed form to the applicant in a sealed envelope with their signature across the back. Applicant is to send this form with the rest of the required admissions information.

TO BE COMPLETED BY THE APPLICANT:

Applicant: _____ Complete Name	Date: _____
Address: _____ Street	Phone: _____
_____	_____
City, State, Zip	Last four digits of SSN
WAIVER OF RIGHT OF ACCESS TO LETTER OF RECOMMENDATION	
The applicant must complete the following statement before submitting the form to the recommender. This request is in compliance with Federal Law P.L. 93-380 (Family Education and Privacy Act of 1974).	
<input type="checkbox"/> Recommendation Form is confidential. I hereby voluntarily waive any right of access to this form.	
<input type="checkbox"/> Recommendation Form is not confidential. I do not waive my right of access.	
_____	_____
Applicant Signature	Date

TO BE COMPLETED BY THE RECOMMENDER:

The individual above is applying for admission to the Hampton University School of Pharmacy. Your recommendation is critical to our admission process. We request that you make every effort to respond objectively to our questions regarding this individual's qualifications. We request that you provide us with some thoughtful feedback within the context of the following:

1. Relevant and factual data about the applicant's intellectual and problem-solving skills in your setting.
2. Your assessment of his/her communication and interpersonal skills in your setting.
3. Your impression of his/her personal qualities (maturity, honesty, adaptability, initiative) and contributions to your practice setting, organization or class.
4. Information that will help us differentiate this applicant from others and the degree of enthusiasm and confidence with which you support this candidate's application.

You may send a letter or statement in addition to this form; however, we require that you also complete the following sections. After you complete the form, please place it in an envelope, seal it and sign it across the seal, and return it to the applicant.

1. How well do you know the applicant? Not well acquainted Slightly Fairly Well Very Well
2. How long have you known the applicant? _____
3. In what capacity? _____

QUALITIES:

	Outstanding Top 5%	Excellent Top 10%	Above Average Top 25%	Average Middle 50%	Below Average Lower 25%	Unable to Rate
Spoken Expression						
Written Expression						
Professionalism						
Emotional Maturity						
Reliability						
Integrity						
Interpersonal Skills						
Self Motivation						
Professional Commitment						
Time Management						
Organizational Skills						
Problem Solving Abilities						

APPLICANT APTITUDE

What is your assessment of the applicant's promise as a Doctor of Pharmacy student? (Give views on matters such as previous accomplishments, intellectual independence, capacity for analytical thinking, ability to work with others, ability to organize and express ideas clearly, verbally and in writing, drive and motivation, and clinical interest.)

PERSONAL/INTERPERSONAL ABILITY

Do you know of any matters related to character and responsibility that could affect the applicant's ability to perform as a Doctor of Pharmacy student?

In respect to your relationship with the applicant, please list what you feel are the applicant's strengths and weaknesses.

(For professional references only): How do you view the applicant's ability to both adapt and contribute to the changing nature of pharmacy practice?

SUMMARY EVALUATION

As a final summary, please choose the following score carefully. The numerical score is used in the formula that ranks each applicant. In comparison with a representative group of individuals who have approximately the same amount of training, education and life experience, what is your OVERALL rating of the applicant?

Outstanding	Excellent	Above Average	Average	Below Average	Unable to rate
10	8	6	4	2	0

Recommender's Name: _____ Position: _____

Address: _____

Telephone Number: _____ Email: _____

Signature: _____ Date: _____

Please return the completed form to the applicant in a sealed envelope bearing your signature across the seal.



**Hampton University
School of Pharmacy**