UNIVERSITY OF MINNESOTA

Twin Cities Campus

Hospital & Special Care Dentistry Fellowship *7-194 Moos Health Science Tower*
Department of Developmental & Surgical Sciences 515 Delaware Street S.E
School of Dentistry Minneapolis, MN 55455-0348

Phone 612-626-0903

Recommendation: Hospital and Special Care Dentistry Fellowship Program

Please send this form to the person you wish to provide a recommendation for you, along with a stamped envelope addressed as follows:

Hospital and Special Care Dentistry Fellowship Program
University of Minnesota School of Dentistry
6-150 Malcom Moos Health Sciences Tower
515 Delaware Street SE, Minneapolis, MN 55455

The applicant should complete this section:

_____ is applying to the University of Minnesota
First name *Middle Name* *Last Name*

School of Dentistry's postdoctoral program in Hospital and Special Care Dentistry.

- I do ____ do not ____agree to waive my right under the Family Education Rights and Privacy Act (FERPA) of 1974 to review specific and composite letters of recommendation.
- I understand that the person providing this recommendation may be contacted to verify or discuss the information provided.

_____ _____
Applicant Signature *Date*

Individual submitting recommendation should complete this section:

Name of individual writing this recommendation: _____

(Please print or type)

Please complete the following form to help us evaluate this application to our program. Our Admissions Committee would also appreciate your individual comments about the applicant's level of skills, aptitude, motivation, initiative and sense of responsibility, as well as dedication to the professional career associated with this program of study. Please return your recommendation to us as soon as possible since this is essential for review of this student's application and the decision on admission must wait until this recommendation is received.

1. How long have you known this applicant? _____ In what capacity? _____

2. Among students at a similar level whom you have known in recent years, how would you rate this student?

Upper 10% ____ Upper 25% ____ Upper 50%____ Lower 50% ___

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3. If known, please give this student's average class standing or rank: ____ out of _____(class size).

4. Please complete the following assessment of this student:

	Excellent	**Good**	**Average**	**Below Average**	**Unknown**
Didactic knowledge					
Clinical skills					
Critical thinking					
Team skills/cooperation					
Interpersonal skills					
Organizational skills					
Industry/conscientiousness					
Reliability/dependability					
Initiative/resourcefulness					
Self-awareness					
Reaction to criticism					
Empathy and compassion					
Maturity					
Professional demeanor					
Integrity					

5. Overall, this student is:

_____ Highly Recommended _____ Recommended ____ Not Recommended

6. Please add any additional comments you feel would be helpful in evaluating this applicant (may use separate sheet):

Signature: _____

Name: _____

Position/Title: _____

(please print)

Professional Address: _____

_____

_____

_____

(City) *(State)* *(Zip/Mail Code)* *(Country)*

Telephone: _____

E-mail: _____