

Residency Applicant Recommendation Request Form 2018-2019

Request for Recommendation by Applicant to PGY-1 MTM Residency

To be completed by applicant: *please print or type*

Name of Applicant: _____
First Name MI Last Name

Street address or P.O. Box

City State Zip Telephone Number

I waive the right to review this recommendation.

Signature of Residency Applicant

To the recommender:

Please complete and return this form **electronically**, by March 9th 2018, to:

Teresa E. Roane, PharmD, BCACP
Center for Quality Medication Management (CQM) at UF
2046 NE Waldo Rd., Suite 3100
Gainesville, FL 32609
troane@cop.ufl.edu

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 program. Recipients of this information are asked to keep the information confidential.

For the recommender to complete:

I have known the applicant for approximately ____ (months) (years).

My relationship to the applicant is/was in the following capacity:

faculty advisor employer
 clerkship preceptor supervisor
 other faculty relationship other (please specify) _____

I know him/her very well fairly well only casually

Please attach a letter of recommendation addressing any special assets the applicant may possess and any weaknesses you feel may hinder his/her ability to successfully complete a pharmacy residency program. Please also include any additional comments which you feel are necessary to effectively evaluate the applicant for a pharmacy resident position.

Contact **Teresa E. Roane** with any questions or concerns:
Email: troane@cop.ufl.edu
Telephone: (352) 273-9692

Relative to persons of similar background, training and professional interests, how would you rate this applicant for each of the following characteristics? Please place an X or ✓ under the rating column which best describes the applicant.

CHARACTERISTICS EVALUATED	UPPER 10%	UPPER 25%	UPPER 50%	LOWER 50%	NO BASIS FOR JUDGMENT
Academic ability					
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					

Recommendation concerning admission (check one):

I highly recommend this applicant.

I recommend this applicant.

I recommend this applicant, but with some reservation.

I am not able to recommend this applicant.

Letter of Recommendation is attached.

Signature of Recommender

Date

Name-typed or printed

Title and affiliation

Street address or P.O. Box

City

State

Zip

Telephone Number

E-mail