

EVALUATION FORM
PARKVIEW HOSPITAL MEDICAL TECHNOLOGY (CLS) PROGRAM

Dear Applicant;

Our Program requires three letters of recommendation, one from each of the following: a biology professor, a chemistry professor, and a present or previous employer. Please complete top part of form and give to your references. Please give each of them a self-addressed, stamped envelope addressed to:

Brian Goff MA, MT(ASCP)
Parkview Health Laboratories
328 Ley Road, Fort Wayne, IN 46825

Applicant Name: _____

I do () I do not () waive my right to subsequent access of this form.

Signature of applicant

Date

Dear evaluator: Please circle the appropriate number with 5 being the best:

Mastery of scientific knowledge:	5	4	3	2	1	N/A
Intellectual capacity:	5	4	3	2	1	N/A
Independent Thinking:	5	4	3	2	1	N/A
Creativity:	5	4	3	2	1	N/A
Flexibility:	5	4	3	2	1	N/A
Maturity/Stability:	5	4	3	2	1	N/A
Personal relations:	5	4	3	2	1	N/A
Motivation:	5	4	3	2	1	N/A
Communication: Oral	5	4	3	2	1	N/A
Written	5	4	3	2	1	N/A

Do you have full confidence in the applicant's integrity? If no, please explain. _____

Relationship to applicant:

Number of years known:

Other Comments: (May use back of form)

Signature

Position/title

Date