THE UNIVERSITY OF TEXAS
MD ANDERSON
CANCER CENTER
Making Cancer History™

LETTER OF RECOMMENDATION FORM

Name of Applicant: _____
Social Security #: _____
Name of Reference: _____

To The Applicant

Please have this form filled out by a professional reference of your choice, following the guidelines on the application.

In accordance with the provisions of the Family Educational Rights and Privacy Act of 1974, P.L.-390 (as amended), with specific reference to Section 438(a)(1)(B) and Subtitle A sections 99.7, 99.11 and 99.12.

I DO _____ DO NOT _____ waive my right of access to and review of this letter of reference I am requesting. NOTE: If you check DO, the recommendation will remain confidential; if you check DO NOT, you may review this recommendation after a decision has been made regarding your acceptance into the program.

Student Signature _____ **Date** _____

To The Reference

The individual named above has applied for admission to the Program in Medical Technology at The University of Texas M.D. Anderson Cancer Center.

We are seeking information that will aid us in the selection of capable students. It is important that students who are selected be able to complete their academic and technical work successfully, and that they possess the personal qualifications essential for a member of the health care team. The applicant has selected you as an individual who can give us such an appraisal. We would appreciate your candid evaluation of the applicant's qualifications. If you prefer to complete an evaluation form used within your own institution or to write a letter, please do so. We know that you are asked to provide many references; we and the applicant are most appreciative of your efforts.

If the applicant has waived his/her right of access (see above), your recommendation will remain confidential. If the applicant has not waived right of access, the applicant will be permitted to review this reference after a decision has been made regarding the applicant's acceptance into the program.

Acquaintance with Applicant

How long and in what connection have you known this applicant? _____

_____

Comments

Please add any descriptive comments that will aid in providing a complete picture of the applicant's abilities and potential as a student and health care professional. Use an extra sheet if needed.

_____

_____

_____

_____

Personal and Professional Appraisal

Please rate the applicant in the following categories, using a scale of 1 to 5 with five being superior and one being poor. If you have no basis for evaluation in any category, please check "No Basis".

Characteristics	Superior 5	4	3	2	Poor 1	No Basis*
Academic Potential						
Leadership						
Technical Laboratory Skills						
Sense of Responsibility						
Ability to Work with People						
Motivation for a Career in Medical Technology						
Ability to Adapt to New Situations						
Ability to Work Independently						
Reliability						
Oral Communication Skills						
Written Communication Skills						
Problem Solving Ability						

***Indicates no basis for evaluation in this category.**

Recommendation

( ) Strongly Recommend **( ) Recommend**
( ) Recommend with Reservations **( ) Do Not Recommend**
(please explain in current section)

Please Type or Print

Your Name _____ **Title** _____

Organization _____

Street Address _____

City _____ **State** _____ **Zip Code** _____

Work Phone Number ( ) _____

Signature _____ **Date** _____

Please Return To:

Karen Rogge-McClure, MS MT(ASCP)SBB
Director – The Medical Technology Program
M.D. Anderson Cancer Center
1515 Holcombe Blvd./Box 037
Houston, TX 77030
(713) 745-1688