



ALVIN COMMUNITY COLLEGE

DIAGNOSTIC CARDIOVASCULAR SONOGRAPHY PROGRAM

Letter of Recommendation

I. To the applicant:

This form is to be given to a professional (not personal) individual familiar with your academic, professional, or personal qualifications. (i.e. employer, supervisor, counselor, instructor)

Applicant (Last Name) (First Name) (Middle Name)

Address

Under the Buckley Amendment, students at Alvin Community College are permitted to see their academic records under certain conditions. I hereby waive & retain the rights thus granted me to see this letter of recommendation should I become a student at Alvin Community College – Diagnostic Cardiovascular Sonography Program.

Signature of Applicant Date

To (Applicant to fill in name of person providing reference)

PLEASE USE THIS FORM ONLY FOR YOUR RECOMMENDATION MAIL TO ADDRESS AT BOTTOM, OR RETURN WITH APPLICANT IN SEALED ENVELOPE

II. The above named person is applying for admission to the Diagnostic Cardiovascular Sonography Program, Alvin Community College, and has given your name as a reference. Would you please comment on the applicants major strengths and weaknesses with regard to graduate study and a career in public health. Please supply any additional information which might help us in considering the applicant and return this recommendation form to the address listed at the bottom of this form.

Five horizontal lines for handwritten response.

Acquaintance with Applicant:

1. How long and in what capacity have you known this applicant?

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

III. Personal and Professional Appraisal: (Please check the category which best indicates your evaluation of the applicant in terms of the listed characteristics.)

Characteristics	Superior	Above Average	Average	No Basis for Evaluation **
A. Academic Potential				
B. Leadership				
C. Professional Competence *				
D. Sense of Responsibility				
E. Ability to Work with People				
F. Rapport with Patients *				
G. Ability to Adapt to New Situations				
H. Ability to Work Independently				
I. Reliability				
J. Oral Communication				
K. Written Communication				
L. Ability to Analyze Problems and Solve them Effectively				

* This category should be completed only by those who have had an opportunity to observe the applicant in a health setting.

** This indicates you have not had the opportunity to observe the applicant in a situation demonstrating this characteristic

IV. Recommendation for Acceptance:

- Strongly recommend Recommend with reservations as noted in the comment section
 Recommend Do not recommend

Please type or print

Your Name: _____ Title: _____
 Organization: _____ Address: _____
 City: _____ State: _____ Zip: _____
 Phone Number: _____ Date: _____
 Signature: _____

Please note: It is not possible to thank each individual personally for completing a recommendation form. We want you to know, however, that we are aware of the time required and both we and the applicant are most appreciative of your response. Please return this signed form to the applicant in a sealed envelope or to the following address:

PLEASE RETURN THIS FORM TO:
Alvin Community College – DCVS Program
Jessica Murphy, Program Director
3110 Mustang Road
Alvin, TX 77511

