

Residency Applicant Recommendation Request Form

Request for Recommendation by Applicant to PGY1 Pharmacy Residency Program at Good Samaritan Regional Medical Center

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 by January 15 to:

Jacqueline D. Joss, Pharm.D.
Good Samaritan Regional Medical Center
3615 NW Samaritan Drive Suite 103,
Corvallis, OR 97330

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. Recipients of this information are asked to keep it confidential.

For the recommender to complete:

I have known the applicant for approximately ____ (months) (years). My relationship to the applicant was (or is) 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

Does the applicant possess any special assets that should be noted?

Does the applicant demonstrate any weaknesses that you feel would hinder his/her ability to perform effectively in a residency program?

Other Comments:

Samaritan Health Services / Good Samaritan Regional Medical Center
 PGY1 Pharmacy Residency

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 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.

Signature of Recommender

Date

Name-typed or printed

Title and affiliation

Street address or P.O. Box

City

State

Zip

Telephone Number