Aurora St. Luke's Medical Center®
of Aurora Health Care Metro, Inc.

School of Radiologic Technology

Recommendation

Applicant Name: _____

☐ I do waive my right to inspect the contents of the following recommendation.
☐ I do not waive my right to inspect the contents of the following recommendation.

Applicant Signature: _____ Date: _____

Recommender: Please complete this section. <u>In addition</u> to this form, please submit a <u>separate letter of recommendation</u>. The letter of recommendation should include how long and in what capacity you have known the applicant. Please return the completed form and letter of recommendation to the applicant in a sealed envelope with your signature across the closure.

Characteristic	Outstanding	Above Average	Average	Below Average	Inadequate Knowledge
Adaptability					
Ability to follow instructions					
Ability to work under pressure					
Attendance / punctuality					
Attitude toward work/school					
Communication skills – oral & written					
Emotional stability & maturity					
Initiative & motivation					
Interpersonal skills					
Quality of work					

The above assessment is based on my observations of and/or interactions with the applicant named above. My assessment is best considered a/an: ☐ Employer ☐ Instructor ☐ Personal reference.

Name: _____ Position: _____ ____

Signature: _____ Date: _____

Organization: _____

Phone: _____ Email: _____