Letter of Recommendation

SUNY Upstate Medical University
College of Nursing

Name of Applicant _____

Social Security # (optional) _____

Application for the _____ Program

Name of Reference _____

To the Applicant:

Please follow the letter of recommendation guidelines which appear in this booklet and complete this section before submitting this form to your reference.

In accordance with the provisions of the Family Educational Rights and Privacy Act of 1974, P.L. 93 - 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.

_____ _____

Signature of Student Date

To the Reference:

The applicant named above has applied for admission to SUNY Upstate Medical University College of Nursing.

We are interested in obtaining information that will aid us in selecting capable students. It is important that students who are selected be able to complete their academic work successfully, and also possess the personal qualifications essential for competent professional performance.

The applicant has selected you as someone who can give us such an appraisal. We would appreciate your candid evaluation of the applicant's qualifications for acceptance to the program. The pending application will be considered incomplete until your response is received.

I. Acquaintance with Applicant:
How long and in what capacity have you known this applicant?

II. Comments: In the space below (use an extra sheet if needed), 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.

(Additional space on reverse)

Please complete both sides.

II. Comments (continued)

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	Below 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 care 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
☐ Recommend with reservations as noted in the comment section
☐ Do not recommend

PLEASE TYPE OR PRINT

Your Name: _____

Title: _____ Professional Credential: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone 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 TO:

College of Nursing Admissions Committee
Office of Student Admissions, 1215 Weiskotten Hall
SUNY Upstate Medical University
766 Irving Avenue
Syracuse, New York 13210