

*Department of Pharmacotherapy and Translational Research*

**Residency Applicant Recommendation Request Form**

**Request for Recommendation by Applicant to PGY-1 MTM/Geriatrics Residency**

**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** February 3rd, 2014 to:

**Teresa Roane, Pharm.D., BCACP**

2046 NE Waldo Rd., Suite 3100

Gainesville, FL 32609

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

Please attach a letter of recommendation addressing any special assets the applicant may possess and any weaknesses you feel may hinder his/her ability to successfully complete a pharmacy residency program. Please also include any additional comments which you feel are necessary to effectively evaluate the applicant for a pharmacy resident position.

Please Contact Teresa Roane with any questions or Concerns:

Email: [troane@cop.ufl.edu](mailto:troane@cop.ufl.edu)

Telephone: (352) 273-9045

You may send a signed copy of this form along with the letter of recommendation via email; however, our residency program requires that the original hard copies with your signature must be received before the applicant may be offered any position of employment.

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, but with some reservation.

\_\_\_ I recommend this applicant. \_\_\_ I am not able to recommend this applicant.

Letter of Recommendation is attached. (Please do not use staples to attach the document.)

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Recommender Date

### 

Name-typed or printed

### 

Title and affiliation

#### 

Street address or P.O. Box City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number E-mail