Presbyterian Medical Center
Radiologic Technology Program

REFERENCE

NOVANT HEALTH

APPLICANT: _____

TO THE APPLICANT: Three (3) Reference forms must be completed and returned to the program to complete your application. **Print your name above**. Distribute or mail this form to an evaluator. The evaluator must mail the completed form directly to the program. It is suggested that you supply a stamped and addressed envelope. Suggested evaluators are instructors, guidance counselors, employers, coaches, and extracurricular activity advisors. Personal friends and relatives are not appropriate. I understand this reference shall be held in the strictest confidence by the Admissions Committee and therefore:

☐ I **DO** waive my right to access this reference as provided by the Family Educational Rights and Privacy Act of 1974. I realize that I will not view or be informed of any portion of this reference.

OR

☐ I **DO NOT** waive my right to access this reference.

_____ _____
SIGNATURE DATE

TO THE EVALUATOR: The above named individual has applied for admission to Presbyterian Medical Center Radiologic Technology Program. The purpose of this reference is to supplement the applicant's academic record, providing valuable assistance in the admission process. If the applicant waived above, your responses will be held in the strictest confidence.

1. Check your evaluation of the following traits:

	OUTSTANDING	VERY GOOD	GOOD	FAIR	POOR	NOT OBSERVED
Maturity of judgment	☐	☐	☐	☐	☐	☐
Ability to accept direction	☐	☐	☐	☐	☐	☐
Ability to accept criticism	☐	☐	☐	☐	☐	☐
Ability to work with others	☐	☐	☐	☐	☐	☐
Motivation and initiative	☐	☐	☐	☐	☐	☐
Perseverance	☐	☐	☐	☐	☐	☐
Reliability	☐	☐	☐	☐	☐	☐
Oral expression	☐	☐	☐	☐	☐	☐
Written expression	☐	☐	☐	☐	☐	☐
Emotional stability	☐	☐	☐	☐	☐	☐

2. Describe major strengths of the applicant:

3. Describe major weaknesses of the applicant:

4. Please state how long and in what capacity you have known the applicant.

5. Check your recommendation of this applicant:

☐ Recommend with Confidence ☐ Recommend with Reservation ☐ Prefer not to Recommend

6. Would you prefer to discuss this reference and request a faculty member to telephone you about this applicant?

☐ Yes ☐ No, it is not necessary

NAME: _____

OCCUPATION/TITLE: _____

EMPLOYER: _____

ADDRESS: _____

_____

TELEPHONE: (_____)_____Day (_____)_____Night

_____

SIGNATURE DATE

Please mail this completed form directly to:

Program Director
Radiologic Technology Program
Presbyterian Medical Center
PO Box 33549
Charlotte, NC 28233-3549

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