Recommendation Form

Carroll Community College

Emergency Medical Services Program

PLEASE TYPE OR PRINT PLAINLY IN INK.

PLEASE MAIL THIS FORM DIRECTLY TO THE PROGRAM DIRECTOR.

To be completed by the applicant. Applicants are encouraged to address and stamp an envelope for the recommender.

____

Last Name *First Name* *Middle Name*

____

Address

Public Law 93-380, Educational Amendment Act of 1974, grants students the right to have access to letters of recommendation in their placement files.

I wish access to my letters. Yes_____ No_____

I waive access to my letters. Yes_____ No_____ ____

Signature *Date*

To be completed by the recommender.

1. Compared with others of similar age and position whom I have known, I would rank this person in the top _______ % of approximately ___________ people I have taught or worked with in _____ years. Please indicate specific ratings below.

	Superior	Above Average	Average	Below Average	Not Acceptable	No opportunity to observe
Intellectual ability						
Breadth of general knowledge						
Ability to express self orally						
Ability to express self in writing						
Openness to values of others						
Emotional maturity						
Imagination creativity						
Ability to empathize with others						

2. Below please comment on the applicant's strengths and weaknesses, emphasizing characteristics that would suggest to you that the person will become a successful (or unsuccessful) student in the Emergency Medical Services program.

Signature____ Position______________________________ Date_________________________

Name printed or typed____

Institution affiliation____

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Street Address City and State Zip Code

Carroll Community College
1601 Washington Road
Westminster, MD 21157

Updated 6/10