



**National University
Master of Science, Nurse Anesthesia Program**

**RECOMMENDATION FORM
Applicant Evaluation by RN, CRNA or Anesthesiologist**

Section one: To be completed by applicant.

Applicant:			
Last	First	Middle	Social Security Number
Applying for class 20_____			
I hereby voluntarily waive and relinquish any right of access to this confidential letter evaluation.		I retain my right of access to this letter of Evaluation.	
Applicant Signature		Applicant Signature	Date
Date			

Section Two: To be completed by RN, CRNA or Anesthesiologist.

Instructions: To be completed by RN, CRNA or Anesthesiologist of the applicant's choosing.

Instructions: An RN, CRNA or Anesthesiologist that possesses professional knowledge of the applicant is asked to complete the remainder of this form.

A letter may be attached in lieu of completing the narrative.

A. Familiarity with Applicant

1. How do you know applicant? How well do you know applicant?



2. How long have you known applicant?

B. Applicant's Personal Attributes

Please evaluate the applicant in each of the following categories by checking the appropriate column.

Personal Attributes	Excellent (upper 10%)	Above Average (upper 33%)	Average (Middle 33%)	Below Average (Lower 10%)	Not Known
Emotional Maturity					
Integrity					
Motivation					
Social Values					
Intellectual ability					
Quality of Expression					
Organization Ability					
Rapport with others					
Leadership Qualities					
Work Ethic					

C. Narrative comments:

Please provide any additional information that you feel would be of value to the Admissions Committee in considering this applicant.



D. Overall Recommendation

Considering all of the applicants to nurse anesthesia programs that you have known, please check the box indication the category in which you would like to place this applicant.

- Recommend enthusiastically – upper 10 percent of applicants
- Recommend with confidence – upper one-third of applicants
- Recommend with reservation – lower one-third of applicants
- Do not recommend (please explain)

E. Evaluator's information:

Nursing Supervisor's Name: _____

Title: _____

Hospital/clinical facility: _____

Mailing Address: _____

City/State _____ / _____ Zip: _____

Phone: _____ Date: _____

Evaluator's Signature: _____ Date: _____

Please return this evaluation in an official sealed envelope with signature across the envelope closure directly to the applicant to include in their supplemental application packet.

Rev: 02/2012