EVALUATION FORM
PARKVIEW HOSPITAL MEDICAL TECHNOLOGY (CLS) PROGRAM

Dear Applicant;

Our Program requires three letters of recommendation, one from each of the following: a biology professor, a chemistry professor, and a present our previous employer. Please complete top part of form and give to your references. Please give each of them a self-addressed, stamped envelope addressed to:

Brian Goff MA, MLS(ASCP)^{CM}
Parkview Regional Medical Center
11109 Parkview Plaza Drive
Fort Wayne, IN 46845

Applicant Name: _____

I do ( ) I do not ( ) waive my right to subsequent access of this form.

_____ _____
Signature of applicant Date

_____

Dear evaluator: Please circle the appropriate number with 5 being the best:

Mastery of scientific knowledge:	5	4	3	2	1	NA
Intellectual capacity:	5	4	3	2	1	NA
Independent Thinking:	5	4	3	2	1	NA
Creativity:	5	4	3	2	1	NA
Flexibility:	5	4	3	2	1	NA
Maturity/Stability:	5	4	3	2	1	NA
Personal relations:	5	4	3	2	1	NA
Motivation:	5	4	3	2	1	NA
Communication - Oral:	5	4	3	2	1	NA
Communication – Written:	5	4	3	2	1	NA

Do you have full confidence in the applicant's integrity? If no, please explain. _____

_____

Relationship to applicant:

Number of years known:

Other Comments: (May use back of form)

_____ _____ _____
Signature Position/title Date