UT COLLEGE OF PHARMACY / UTMC
PGY2 CRITICAL CARE PHARMACY RESIDENCY APPLICATION

REQUEST FOR RECOMMENDATION

To be completed by the applicant

Name of Applicant:
(Please print or type)

First Name MI Last Name

Street Address or P.O. Box

City State Zip

( ) -
Telephone

I waive the right to review this recommendation.

Signature of Residency Applicant

To be completed by individual completing the recommendation

Applicants to our residency program are required to have letters of recommendation submitted by persons who are in a position to evaluate their qualifications for residency training. The individual completing the recommendation is asked to make an honest appraisal of the applicant's character, personality, abilities, and suitability for a pharmacy residency. All comments and information provided will be kept in strict confidence as allowed by Ohio Law. In your letter of recommendation, please address each of the following:

- How long you have known the applicant and in what capacity?
- What are the applicant's strengths and weaknesses?
- How would you rate the applicant's time management skills?
- How is the applicant able to deal with difficult personalities and situations?
- How is the applicant motivated to perform at a high level in stressful situations?
- What is your recommendation on the applicant's candidacy?

Signature of individual completing the recommendation

Typed or printed name and title

Institution/Company

Address or P.O. Box

City State Zip

( ) - ( ) -
Telephone Fax

The letter of recommendation should be mailed or faxed to:

Martin J. Ohlinger, PharmD, BCPS
University of Toledo College of Pharmacy
Wolfe Hall Suite 1246 MS 609
2801 W. Bancroft St.
Toledo, OH 43606
Fax: 419.530.1951