Department of Biomedical Sciences
Attn: Graduate Coordinator MSCMB
Missouri State University
901 South National Ave.
Springfield, MO 65897-0094

Instructions: Part 1 must be completed and signed by the applicant before submitting to the individual providing the recommendation. Part 2 must be completed and mailed to the address at the left (or faxed to 417 836-5588) by the person writing the recommendation). This blank form may be copied.

Part 1: (to be completed by the applicant who is soliciting a letter of recommendation)

RECOMMENDATION FOR: (please check one or both)

____ ADMISSION INTO MASTER OF SCIENCE IN CELL AND MOLECULAR BIOLOGY PROGRAM

____ GRADUATE ASSISTANTSHIP IN THE DEPARTMENT OF BIOMEDICAL SCIENCES

_____ _____ _____ _____
SIGNATURE OF APPLICANT | PRINTED NAME OF APPLICANT | SOCIAL SECURITY # | DATE

I elect (check one) ___ A confidential file that will not be subject to my inspection
___ A non-confidential file that will be subject to my inspection

Requested beginning date: (fill in year)
Aug _____ Jan _____ June _____

If there are questions, I may be reached at:
_____

Part 2: (to be completed by the individual providing a recommendation)

Please give your qualitative impression of this student in comparison to other graduate applicants.

Qualitative Impression: (please check one) ____ upper 10%; ____ upper 25%; ____ upper 50%; ____ lower 50%

We are particularly interested in your assessment of the applicant's ability to pursue graduate study with a high level of success, the applicant's teaching/research potential and motivation, and the applicant's strengths and weaknesses. You may use the space below and the back of the page, if needed, or include an accompanying letter of recommendation with this form attached.

_____ _____ _____
Printed Name | Signature | Date

_____ _____
Position/Department | Address

_____
City/State/Zip