



LETTER OF RECOMMENDATION FORM

Name of Applicant: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Name of Reference: \_\_\_\_\_

To The Applicant

**Please have this form filled out by a professional reference of your choice, following the guidelines on the application.**

**In accordance with the provisions of the Family Educational Rights and Privacy Act of 1974, P.L.-390 (as amended), with specific reference to Section 438(a)(1)(B) and Subtitle A sections 99.7, 99.11 and 99.12.**

**I DO \_\_\_\_\_ DO NOT \_\_\_\_\_ waive my right of access to and review of this letter of reference I am requesting. NOTE: If you check DO, the recommendation will remain confidential; if you check DO NOT, you may review this recommendation after a decision has been made regarding your acceptance into the program.**

**Student Signature \_\_\_\_\_ Date \_\_\_\_\_**

To The Reference

**The individual named above has applied for admission to the Program in Cytogenetic Technology at The University of Texas M.D. Anderson Cancer Center.**

**We are seeking information that will aid us in the selection of capable students. It is important that students who are selected be able to complete their academic and technical work successfully, and that they possess the personal qualifications essential for a member of the health care team. The applicant has selected you as an individual who can give us such an appraisal. We would appreciate your candid evaluation of the applicant's qualifications. If you prefer to complete an evaluation form used within your own institution or to write a letter, please do so. We know that you are asked to provide many references; we and the applicant are most appreciative of your efforts.**

**If the applicant has waived his/her right of access (see above), your recommendation will remain confidential. If the applicant has not waived right of access, the applicant will be permitted to review this reference after a decision has been made regarding the applicant's acceptance into the program.**

Acquaintance with Applicant

**How long and in what connection have you known this applicant? \_\_\_\_\_**

\_\_\_\_\_

Comments

**Please add any descriptive comments that will aid in providing a complete picture of the applicant's abilities and potential as a student and health care professional. Use an extra sheet if needed.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please rate the applicant in the following categories, using a scale of 1 to 5 with five being superior and one being poor. If you have no basis for evaluation in any category, please check "No Basis".

Characteristics	Superior 5	4	3	2	Poor 1	No Basis*
<b>Academic Potential</b>						
<b>Leadership</b>						
<b>Technical Laboratory Skills</b>						
<b>Sense of Responsibility</b>						
<b>Ability to Work with People</b>						
<b>Motivation for a Career in Cytogenetic Technology</b>						
<b>Ability to Adapt to New Situations</b>						
<b>Ability to Work Independently</b>						
<b>Reliability</b>						
<b>Oral Communication Skills</b>						
<b>Written Communication Skills</b>						
<b>Problem Solving Ability</b>						

## Recommendation

- ☐ Strongly Recommend                      ☐ Recommend  
☐ Recommend with Reservations        ☐ Do Not Recommend  
 (please explain in current section)

Your Name \_\_\_\_\_ Title \_\_\_\_\_  
 Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Work Phone Number ( ) \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please Return To:** Vicki L. Hopwood, MS, CLSP(CG)  
Director - Cytogenetic Technology Program  
Department of Pathology, Box 53  
UT M.D. Anderson Cancer Center  
1515 Holcombe Boulevard  
Houston, Texas 77030  
Tel. #713/795-1688