

Doctor of Physical Therapy Program *Recommendation Form*

Applicant: Last Name _____

First Name _____

Waiver

The Family Education Rights and Privacy Act of 1974 (FERPA) gives applicants the right to access letters of recommendation written unless they choose to waive their right of inspection and review. Prior to requesting a recommendation from each evaluator, the applicant is required to indicate whether they wish to waive this right. The applicant's decision to waive or not waive access to this recommendation will be released to the program's admissions personnel.

- I waive my right of access to this letter of recommendation
- I do NOT waive my right of access to this letter of recommendation

Applicant Authorization

In order for Adventist University of Health Sciences (ADU) Enrollment Services to process the applicant's recommendations, the applicant must certify (☒) the following statements:

- It is my sole responsibility to contact the evaluator directly to ensure all recommendations required by the University and my designated program are received by the deadline.
- I understand that the University and/or its program to which I am applying may contact the evaluator either to verify the information provided and/or for further clarification of the information provided, and I hereby give permission for the University and/or program to do so.

Applicant's Signature: _____ **Date:** _____

Name of Evaluator: _____

INSTRUCTIONS FOR EVALUATORS

- Complete the ADU Doctor of Physical Therapy Program Recommendation Form
- Attach the completed form to a letter of recommendation (printed on institutional or professional letterhead preferred).
- Cite specific instances or evidence to support your comments in the recommendation letter.
- Send to ADU at your earliest convenience in order to ensure that the applicant will not miss any deadlines.
- Submit your letter of recommendation and completed form in a single sealed envelope to the address below:

Office of Enrollment Services
Adventist University of Health Sciences
671 Winyah Drive
Orlando, FL 32803

The program will not consider a paper recommendation unless this form is completed and attached.

The program will not accept recommendations mailed by applicants.

We greatly appreciate your time and effort to prepare this recommendation.

If you have questions, you may contact ADU's Office of Enrollment Services at 407-303-7742 or email dpt.info@adu.edu.



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INSTRUCTIONS TO EVALUATORS: PLEASE ENTER YOUR CONTACT INFORMATION BELOW

Evaluator' Name: _____

Position: _____

Name of Institution or Organization: _____

Department or Division: _____

Street Address 1: _____

Street Address 2: _____

City: _____ State: ____ Zip/Postal Code: _____

Country: _____

Email Address: _____ Phone: _____

PLEASE RESPOND TO THE FOLLOWING QUESTIONS REGARDING THE APPLICANT:

How long have you known the applicant? Years: _____ Months: _____

How well do you know the applicant? Very Well Moderately Minimally Not at All

With what organization or institution were you affiliated when you interacted with the applicant?

Select one role that BEST describes your primary interaction with the applicant:

- | | | |
|--|--|---|
| <input type="checkbox"/> Academic | <input type="checkbox"/> Health Care Professional | <input type="checkbox"/> Professor in Major |
| <input type="checkbox"/> Clergy | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Physical Therapist Assistant |
| <input type="checkbox"/> Co-worker | <input type="checkbox"/> Politician/Elected Official | <input type="checkbox"/> Supervisor/Employer |
| <input type="checkbox"/> Family Member | <input type="checkbox"/> Pre-PT Advisor | <input type="checkbox"/> Teaching Assistant |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Professor | <input type="checkbox"/> Other: _____ |

Approximately how many recommendations do you submit on behalf of PT applicants each year? _____

Are you a licensed physical therapist? Yes No

IF YOU ARE A PHYSICAL THERAPIST, ANSWER THE FOLLOWING QUESTIONS:

Physical therapist institution from which you graduated: _____

Enter the state(s) in which you are licensed to practice physical therapy: _____

Enter your PT licensure number(s): _____

IF YOU ARE A PROFESSOR, ANSWER THE FOLLOWING QUESTION:

List all courses in which you had the applicant as a student (e.g., Intro to Chemistry, CHEM 101). If you cannot remember courses names or numbers, list the content area and the course level (undergraduate upper or lower division; or graduate level).

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How would you rate the applicant for each of the following characteristics?

(Please select the rating that best describes the applicant in the category. Select "N/O" for not observed, if you have not had an opportunity to evaluate the characteristic or have no basis for the assessment.)

	Excellent (5)	Good (4)	Average (3)	Below Average (2)	Poor (1)	N/O (0)
Commitment to Learning — the ability to self-assess, self-correct and self-direct; identify needs and sources of learning; continually seek new knowledge and understanding.	<input type="checkbox"/>					
Interpersonal Skills — the ability to interact effectively with patients, families, colleagues, other healthcare professionals and the community; deal effectively with cultural or ethnic diversity issues.	<input type="checkbox"/>					
Communication Skills — the ability to communicate effectively (speaking, body language, reading writing, listening) for varied audiences and purposes.	<input type="checkbox"/>					
Effective Use of Time — the ability to obtain the maximum benefit from a minimum investment of time and resources.	<input type="checkbox"/>					
Use of Constructive Feedback — the ability to identify sources of and seek out feedback; to effectively use and provide feedback for improving personal interaction.	<input type="checkbox"/>					
Ethical and Professional Behavior — the ability to exhibit appropriate ethical and professional conduct and to represent the profession effectively.	<input type="checkbox"/>					
Responsibility — the ability to fulfill commitments, be accountable for actions and outcomes, and to persevere to achieve goals.	<input type="checkbox"/>					
Critical Thinking — the ability to question logically; identify, generate and evaluate elements of logical argument; recognize and differentiate facts, illusions, and assumptions; distinguish the relevant from the irrelevant.	<input type="checkbox"/>					
Stress Management — the ability to identify sources of stress, develop effective coping behaviors, and adapt well to change.	<input type="checkbox"/>					
Problem Solving — The ability to recognize and define problems, use imagination and creativity to solve problems, analyze data, develop and implement solutions, and evaluate outcomes.	<input type="checkbox"/>					
Leadership — the ability to take initiative and motivate or guide others; generates ideas and plans or shares a vision for the future.	<input type="checkbox"/>					

Taking into consideration these characteristics, how do you think this person would perform as a health care provider?

- I highly recommend this applicant as a health care provider.
- I recommend this applicant as a health care provider.
- I recommend this applicant as a health care provider, but with some reservations.
- I am not able to recommend this applicant as a health care provider.

Evaluator's Signature _____

Date _____

Comments — On your institutional or business letterhead, please comment on any of the ratings or provide any additional information that will help the admissions office in the application review process. Attach letter to this recommendation form.