



SUMMER PREMED PROGRAM

UC IRVINE SCHOOL OF MEDICINE

Phone: 714.456.3429 E-mail: summerpremed@uci.edu

Teacher Recommendation Form

Applicant's Name: _____ Date: _____

High School Name: _____

Please give this form to your teacher to send directly to us. Please sign below if you waive your right to access this recommendation letter.

Signature of applicant: _____

Dear Evaluator:

Please evaluate the above applicant in relation to other students at the same level of training.

How well do you know this applicant? (Please include length of time and your association.)

Outstanding = top 10% Good = top 25% Average = 50% Poor = bottom 10%

Rating of Characteristics	Outstanding	Good	Average	Poor	No opinion
Motivation					
Dedication					
Reliability					
Self-Confidence					
Maturity					
Written Expression					
Communication					
Interpersonal Relationships					
Intelligence					
Leadership capability					

Other comments or concerns (attach additional pages if needed):

