

Office of Admissions
VCU School of Dentistry
P.O. Box 980566
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(804) 828-9196 FAX: (804) 828-5288

EVALUATION FORM

Part I

Waiver (Check one):

- ☐ I have waived right of access to this evaluation
- ☐ I do not waive my right of access to this evaluation

Candidate's Name (type or print): _____

Candidate's AADSAS #: _____

Part II

1. My evaluation of the candidate is based on the following(s):

- | | |
|--|----------------------------------|
| <input type="checkbox"/> Lecture/Seminar | <input type="checkbox"/> Advisor |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Dentist |

2. Please indicate your **overall** recommendation of this candidate:

- ☐ Recommend ***Enthusiastically***
- ☐ Recommend with ***Confidence***
- ☐ Recommend
- ☐ Recommend with ***Reservations***
- ☐ Not Recommended

Please complete the following based on the candidate's performance as witnessed by you.

Attributes	Poor	Below Average	Average	Above Average	Outstanding	Not Observed
Ability to adapt to supervision, take instruction, relate positively to teachers and/or supervisors						
Ability to get along with others						
Willingness to work; work habits						
Accuracy; careful; definite; exact						
Analytical skills						
Communication skills						
Dependability						
Independence; ability to get along without supervision						
Intellectual curiosity						
Intelligence; natural ability to succeed in academic efforts						
Judgment						
Organizational skills						
Perseverance						
Personal integrity						
Poise						
Professional Appearance/Demeanor						

Your general assessment of this candidate as a potential dental student – include the candidate's major strengths and weaknesses as you see them. For additional comments please use a separate page.

Evaluator's Name (type or print): _____ Date: _____

Evaluator's Signature: _____

E-mail Address: _____ Phone number (Day): _____

Address: _____
