SUMMER PREMED PROGRAM
UC IRVINE SCHOOL OF MEDICINE

Phone: 714.456.6719 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):

_____
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Overall recommendation: Strongly recommend ___ Recommend ___ Do not recommend ___

Name of Evaluator (Please print legibly):_____

Signature: _____ Date: _____

Teacher's e-mail address _____

High School Name: _____ Phone: _____

Address: _____

Please mail or fax the completed form to:

Molly Blair
UC Irvine Summer Premed Program
333 City Blvd West, Suite 2100
Orange, CA 92868
Fax: 714.456.5062 (Attn: Kristina)

Or scan and e-mail to: summerpremed@uci.edu