DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention

Re: _____
Applicant's Name

Dear Colleague:

The person identified above has applied to the Preventive Medicine Residency and Fellowship (PMR/F) at the Centers for Disease Control and Prevention and indicated that you will be writing a letter of recommendation for his/her application. The Residency is a 24-month program accredited by the Accreditation Council for Graduate Medical Education (ACGME) and meets the residency requirement of the American Board of Preventive Medicine (ABPM) for the Public Health and General Preventive Medicine specialty. The Fellowship is a 12-month program similar to PMR intended for clinicians and for physicians who do not meet eligibility criteria for the Residency.

Enclosed is a list of items we would like for you to address in your letter. We would appreciate a frank and objective evaluation of the applicant.

The applicant must submit your letter in a sealed envelope along with other required documents.

Your prompt response is appreciated.

Sincerely yours,

Asim Jani, MD, MPH, FACP
Commander, USPHS
Director, Preventive Medicine Residency and Fellowship
Division of Scientific Education and Professional Development
Centers for Disease Control and Prevention

Enclosure (2 pages)

To Be Completed by Applicant

After supplying your information below, give this document to your immediate supervisor and two others familiar with your work in public health.

Applicant's Last Name First Middle

Under the provision of the Family Educational Rights and Privacy Act of 1974, you may decide whether letters of recommendation written at your request are to be held confidential or whether they are to be available for your personal inspection. Please check one of the following statements and sign as indicated.

☐ I expressly waive any rights I might have of access to this letter of recommendation under the Family Educational Rights Act of 1974, or any other law, regulation, or policy.

☐ I do not agree to the waiver above.

Signature (Applicant) Date

To Be Completed by Evaluator

Name (Evaluator) Title

Occupation Phone #

Organization Address

1. How long have you known the applicant? _____

2. What is your relationship to the applicant (employer, immediate supervisor, secondary supervisor)?

3. Does the applicant have any special talents, abilities, or attributes in the context of their professional activities?

4. Does the applicant have any particular areas in need of improvement in the context of their professional activities?

5. Compare the applicant with other physicians, veterinarians, nurses, dentists, physician assistants you know with the same background. Please identify your referent group.

Referent group: _____

Categories Observed	Superior Top 2 %	Excellent Top 10%	Above Average Top 25%	Average 25–75%	Below Average Bottom 25%	Not Observed
Intellectual ability	☐	☐	☐	☐	☐	☐
Career commitment to public health	☐	☐	☐	☐	☐	☐
Interest in specialty of preventive medicine	☐	☐	☐	☐	☐	☐
Ability to complete work on time	☐	☐	☐	☐	☐	☐
Initiative and motivation	☐	☐	☐	☐	☐	☐
Ability to work independently without close supervision	☐	☐	☐	☐	☐	☐
Ability to work with others	☐	☐	☐	☐	☐	☐
Leadership potential	☐	☐	☐	☐	☐	☐
Emotional maturity	☐	☐	☐	☐	☐	☐
Ability to balance program and personal needs	☐	☐	☐	☐	☐	☐
Desire for board certification in preventive medicine	☐	☐	☐	☐	☐	☐

Narrative Statement:
Attach a narrative statement including any information (e.g., work ethic, flexibility, adaptability, interpersonal skills) which you feel would be of value in considering this applicant.

Overall Evaluation:
Please indicate your opinion as to whether the applicant should be admitted to the PMR/F

☐ Recommend **very strongly**
☐ Recommend **strongly**
☐ Recommend
☐ Recommend **with reservation**
☐ **Do not** recommend

May we contact you regarding this evaluation? ☐ Yes ☐ No

Signature: _____ Date: _____

Seal letter of recommendation in an envelope and return to applicant.