

Recommendation Form

Master of Science in Nursing Program

Name _____

FIRST MIDDLE MAIDEN LAST

Present Address _____

CITY COUNTY STATE ZIP

Name of Evaluator _____

LAST FIRST MIDDLE

☐ Academic ☐ Employer

APPLICANT

1. Please complete the information above.

2. Read the statement below and, if you choose, sign it where indicated. The Family Education Rights and Privacy Act of 1974 entitles School of Nursing graduate students to have access to letters of evaluation in their records at the School. The applicant may waive the right of access to letters of evaluation in which case letters of evaluation will be considered confidential by the School of Nursing and will not be available to the student. If you wish to waive your right to access this letter of evaluation, please sign your name on the line below the following statement.

I, the undersigned, hereby waive all rights or privileges provided by Public Law 93-380 to inspect or challenge the content and comments appearing in this letter of evaluation.

Applicant's Signature _____ Date _____

3. Please use legal-sized envelopes. Please type or print your name and address on the front of the envelope and mail it with this form to the evaluator you have identified above.

RECOMMENDER

Please complete the information requested on both sides of this form. If you need additional sheets of paper please staple them to this form. Your comments will be held completely confidential if the applicant has signed the statement above. Please enclose this form and any attachments in the envelope addressed to the applicant. Please sign the back of the envelope, writing your signature across the seal of the envelope flap and return sealed envelope to the applicant.

Please evaluate the applicant's qualifications by checking the appropriate spaces below.

PROPOSED SPECIALITY

- ☐ Acute Care Nurse Practitioner
- ☐ Acute Care Nurse Practitioner
Intensivist
- ☐ Adult-Gerontology Primary Care
Nurse Practitioner
- ☐ Emergency Nurse Practitioner *
- ☐ Family Nurse Practitioner
- ☐ Family Psychiatric and Mental
Health Nurse Practitioner
- ☐ Health Systems Management
- ☐ Neonatal Nurse Practitioner
- ☐ Nurse-Midwifery *
- ☐ Nurse-Midwifery/FNP Dual Focus *
- ☐ Nursing Informatics
- ☐ Pediatric Acute Care Nurse
Practitioner
- ☐ Pediatric Primary Care Nurse
Practitioner
- ☐ Urogynecology (Post Master's)
- ☐ Women's Health Nurse Practitioner
- ☐ Women's Health Nurse
Practitioner/ Adult Gerontology
Nurse Practitioner *

Dual Degrees: On Campus Online

☐ MSN/MDiv & MSN/MTS*

*Additional semester(s) required

QUALIFICATIONS	EXCELLENT	GOOD	AVERAGE	BELOW AVERAGE	NO BASIS FOR JUDGEMENT
Intellectual Ability					
Critical thinking					
Inquisitiveness					
Knowledge in subject of proposed study					
Verbal communication of ideas					
Written communication of ideas					
Industry and perseverance					
Emotional stability					
Self-image					
Independence					
Creativity-Imagination					
Leader ability					

2. Please describe your relationship to the applicant and how long you have known her/him.

3. The School of Nursing appreciates your statement concerning this applicant. Please comment on the following: Estimate of character, and how well qualified he/she is for advanced study in nursing.

4. Do you know of any special circumstances in the applicant’s social or academic background or emotional makeup that should be considered in the evaluation of this applicant for graduate studies?

Signature_____ Date _____

Name (please print) _____

Position or Title_____ Daytime phone number _____

Full Address _____

NON- DISCRIMINATION POLICY

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