

MASTER'S IN GENETIC COUNSELING TRAINING PROGRAM

University of Maryland, Baltimore
685 West Baltimore St., MSTF 3-14G
Baltimore, Maryland 21201
Phone: (410) 706-4713 Fax: (410) 706-1644

RECOMMENDATION FORM

Instructions to applicant: Complete the information below, then give this form to the person who will offer a recommendation on your behalf. Provide this person with an envelope addressed to the program. This form is to be sent directly to the program. You may copy this form if additional copies are necessary.

Social Security Number:

Last Name: _____ First Name: _____ M.I. _____

Home Phone: (____) _____ Work Phone: (____) _____

Address: _____ City: _____

State/Country: _____ Zip: _____ E-mail address: _____

Public Law 93-380, Educational Amendment Acts of 1974 grants students the right to have access to letters of recommendation in their placement files.

I wish to waive access to my letters: Yes No

Applicant's Signature: _____ Date: _____

Instructions to the recommender: Write a short assessment of the applicant in the space below. We are particularly interested in the applicant's strengths, weaknesses, and characteristics that would help the Faculty Review Committee judge the applicant's ability to succeed in graduate education. Continue on the other side of this sheet if necessary or use your own letterhead and attach to this form. Please also give your impression of the applicant in the chart below.

	Excellent	Above Average	Average	Below Average	Poor	Unable to Assess
Analytical Ability						
Breadth of Knowledge						
Verbal Expression Skills						
Written Expression Skills						
Perseverance						
Maturity						
Imagination and creativity						
Potential as a counselor/teacher						
Overall academic potential						

Print Name and Title: _____

Institutional Affiliation: _____

Institutional Address: _____

Telephone: (____) _____ E-mail: _____

Signature: _____ Date: _____