NUCLEAR MEDICINE PROGRAM
School of Health Professions
University of Missouri

RECOMMENDATION FORM

APPLICANT
This Recommendation Form should be given to a person who knows you well and is able to judge your academic or work qualifications for this professional program. Complete your contact information in the box and submit to a recommender of your choice. Review the application instructions for further information.

Applicant Information

Applicant's Name: ___________________________ Student ID#: ___________________________

Mailing Address: ________________________________________________________________

Email Address: ___________________________ Telephone: ___________________________

RECOMMENDER
The applicant whose name appears above has applied for admission to the University of Missouri Nuclear Medicine Program. We would appreciate your assessment of the applicant’s attributes with which you are familiar. Please answer each item below and submit to the Nuclear Medicine Admissions Office by December 1st.

How long have you known the applicant? From ___________________________ to ___________________________

Relationship to applicant: [ ] Employer/Supervisor [ ] Teacher/Professor/TA [ ] Counselor/Advisor/Mentor
[ ] Clergy [ ] Other ___________________________

I request to have this recommendation be treated as [ ] confidential [ ] non confidential.

Instructions: For each trait evaluate the applicant on actual performance. Pick the description which best fits the person for each trait and check the appropriate box.

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<th>Traits</th>
<th>Outstanding</th>
<th>Superior</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Not Observed</th>
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<tr>
<td>School performance or work record</td>
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<td>Initiative</td>
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<td>Maturity</td>
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<td>Ability to work under supervision</td>
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<td>Rapport with peers</td>
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What, in your opinion, are the applicant's major strengths?
What, in your opinion, are the applicant's major weaknesses?

Additional Comments?

**Recommendation:**  
- [ ] Qualified & Competent  
- [ ] Reservations  
- [ ] Not Recommended

Evaluator's Name: ___________________________  
Company: ___________________________

Position: _________________________________  
Address: _________________________________

Email: _________________________________  
Phone: _________________________________

*If returning this form via mail or fax:*

Evaluator’s Signature: ____________________________________________

**Please return by February 1st directly to the admissions committee via:**

- **Email:**  KoehnA@health.missouri.edu
- **Mail:**  
  Nuclear Medicine Admissions Committee  
  School of Health Professions  
  University of Missouri  
  605 Lewis Hall  
  Columbia, MO  65211-4230
- **Fax:**  573-884-1490