Recommendation Form

BISMARCK STATE COLLEGE
Diagnostic Medical Sonography

Name of Applicant: _____

Name of Evaluator: _____

Please complete this recommendation form **and** submit a separate letter of recommendation (including the applicant's strengths, weaknesses, and anything you feel the DMS program should know about the applicant). All recommendation forms/letters are kept strictly confidential and are destroyed after the selection process and not kept as part of any permanent file. Place both items in a **sealed envelope with your signature over the seal**. The sealed recommendation form and letter can be given back to the applicant to be submitted with their application materials OR mailed directly to: Bismarck State College
Diagnostic Medical Sonography Program Director
PO Box 5587
Bismarck, ND 58506

1. How long have you known the applicant? _____
2. In what capacity have you known the applicant? _____
3. How well do you know the applicant? □ Very well □ Fairly well □ Slightly

Please rate the applicant on the following characteristics below: (5 being the highest, 1 the lowest)

	5 Highest	4	3	2	1 Lowest	Unable to evaluate
Acceptance of criticism						
Adaptability						
Ability to follow instructions						
Ability to multitask						
Attendance / Punctuality						
Attitude						
Communication skills						
Decision making						
Emotional stability						
Grooming and hygiene						
Honesty						
Initiative and motivation						
Professionalism						
Quality of performance						
Reaction to stress						
Teamwork						
Work ethic						

What is your overall impression of this candidate? (check one)
□ Would highly recommend □ Would recommend with some reservation □ Hesitate to recommend

Signature of evaluator: _____ Date: _____

Name of evaluator (printed): _____ Position / title: _____

Place of employment: _____