STUDENT REFERENCE FORM PARKVIEW MEDICAL LABORATORY SCIENCE (MLS) PROGRAM

Dear Applicant,

Our Program requires three letters of recommendation, one from each of the following: a biology professor, a chemistry professor, and a present or previous employer. Please complete the top part of the form and give the form to your references. Please give each of them a stamped, self-addressed envelope addressed to:

Allegra McMillen MEd, MLS(ASCP)^{CM}

Parkview Medical Laboratory Science Program, 2200 Randallia Drive, Fort Wayne, IN 46805 or via email at Allegra.McMillen@parkview.com

Signature of applicant			D			
Dear evaluator: Please circle the a	ppropriate nur	nber with	5 being the	best:		_
Mastery of scientific knowledge:	5	4	3	2	1	
Intellectual capacity:	5	4	3	2	1	
Independent Thinking:	5	4	3	2	1	
Creativity:	5	4	3	2	1	
Flexibility:	5	4	3	2	1	
Maturity/Stability:	5	4	3	2	1	
Personal relations:	5	4	3	2	1	
Motivation:	5	4	3	2	1	
Communication - Oral:	5	4	3	2	1	
Communication – Written:	5	4	3	2	1	
Do you have full confidence in the a	pplicant's integ	rity? If no,	please expl	ain		
Number of years known:						
Other Comments: (May use back of	form)					
Signature Pos	sition/title			te		