



RECOMMENDATION REQUEST PGY1 PHARMACY PRACTICE RESIDENCY

Section One – To be completed by applicant

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

Applicants to the residency program specified above are required to have recommendations submitted by persons who are in a position to evaluate their qualifications for residency training. The recommender is asked to make a frank appraisal of the applicant’s character, personality, abilities, and suitability for a pharmacy residency. All comments and information provided will be kept in strictest confidence.

I waive the right to review this recommendation:

Signature of Applicant: _____ **Date:** _____

Section Two – To be completed by recommender

I have known the applicant for approximately _____ months/years

My relationship to the applicant is/was in the following capacity:

Faculty Advisor Clerkship Preceptor Other Faculty Relationship Other: _____

I know him/her: Very Well Fairly Well Only Casually

Relative to person’s similar background, training, and professional interests, how would you rate this applicant for each of the following characteristics? (Place an X under the rating column which best describes the applicant.)

Characteristic Evaluated	Upper 10%	Upper 25%	Upper 50%	Lower 50%	No Basis
Academic Ability					
Quality of Work					
Written Communication Skills					
Oral Communication Skills					
Leadership Skills					
Industriousness and Perseverance					
Initiative and Motivation / Assertiveness					
Cooperativeness					
Ability to Work with Peers					
Ability to Work with Patients					
Ability to Organize / Manage Time					
Dependability					
Resourcefulness and Originality					
Personal Appearance/ Professional Demeanor					
Commitment to Professional Practice					
Emotional Stability and Maturity					
Enthusiasm					
Integrity					

ASSETS: Does this applicant possess any special assets that should be noted?

DEFICIENCIES: Does the applicant demonstrate any weakness that you feel would hinder his/her ability to perform effectively in a residency program?

OTHER COMMENTS:

RECOMMENDATION (check one):

Highly recommend Recommend Recommend with reservation Do not recommend

Last Name: _____ First Name: _____ Middle Initial: _____

Title and Affiliation: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Signature of Recommender: _____ **Date:** _____

Please complete and return this form by January 16th to:

Christine Price, Pharm.D.
Morton Plant Mease Health Care
Department of Pharmacy
300 Pinellas Street, MS #51
Clearwater, FL 33756