

St. Joseph's College of Nursing
at St. Joseph's Hospital Health Center
Syracuse, New York

Confidential Recommendation

Applicant: Please complete the following section

Last Name _____ First _____ Middle _____

Permanent Address _____

City _____ State _____ Zip Code _____

Pursuant to federal law, a student admitted to the College of Nursing is entitled to inspect the recommendation unless the student waives the right. The College of Nursing does not require a waiver as a condition for admission, receipt of financial aid, or receipt of any other services or benefits.

Waiver

*The Family Education Rights and Privacy Act permits us to request, but not require, that a student waive the right to inspect this recommendation. Be advised that the information contained on this form will be used to evaluate the student's eligibility for admission to St. Joseph's College of Nursing. **Should the student elect to waive the right to access and review this information please sign and date below:***

_____ Date

_____ Signature

Evaluator: Please complete the following section

In what capacity have you known the applicant? _____

How long have you known the applicant? _____

Estimate of applicant's future success at St. Joseph's College of Nursing:

Superior Above Average May Encounter Difficulty Little Chance of Success

Overall Recommendation: Enthusiastically Recommended Recommend

Not Recommended Prefer Not to Make a Recommendation

	strong	average	weak	unable to evaluate
Accountability/ Responsibility				
Communication Skills				
Critical Thinking				
Integrity				
Interpersonal Skills				
Leadership				
Learning Potential				
Self-Direction				
Stress Management				
Time Management				

Evaluator Remarks

Please indicate any information relevant to the student's application to St. Joseph's College of Nursing

Evaluator Signature _____ Date: _____

Printed Name _____

Position/Title _____

Agency Address _____

Telephone _____ Email _____