Inter American University of PR
Metropolitan Campus
Science and Technology Faculty
School of Medical Technology

Recommendation Letter Form

Applicant Name: _____

TO THE APPLICANT: Please complete this section prior to submitting this form to your reference. In accordance with the Education Law of Privacy Law of 1974, I give up my rights to have access to this letter of recommendation, which will be considered as strictly confidential.

Please check one: ____ I waive my right of access to this letter of recommendation.
____ I DO NOT waive my right of access to this letter of recommendation.

Applicant Signature: _____ Date: _____

TO THE EVALUATOR: The above-named applicant has applied for admission to the School of Medical Technology at Inter American University of PR, Metro Campus. Please complete the following information and return it to the address on the final of this form. You may write an additional page for comments.

Please rate the applicant on the following characteristics using a scale of 1 to 10 with 10 being superior and 1 being poor. Write the number. Mark "No Basis" if you have no basis for evaluation.

	Superior 10-9	Good 8-6	Average 5-4	Deficient 3-2	Poor 1	No Basis	Comments
Leadership: Impression about commitment, initiative and motivation							
Responsibility: attendance, punctuality, honesty and integrity							
Attitude skills and appearance: Act with maturity and serenity. Its appearance is clean and pleasant.							
Interpersonal Skills: Accept criticism and suggestions. Communicates effectively and shows respect, consideration and adaptability.							
Academic Potential: It covers assigned and additional material. Shows talent, intelligence and creativity.							
Technical Laboratory Skills: work with precision, reliability and promptness. The student follow instructions, reach reasonable conclusions, have ability to problem solving and rapidly adapt to changes.							

In what capacity have you known this applicant? ( ) Lecture ( ) Laboratory ( ) Seminar ( ) Other: _____

Evaluator Information:

Evaluator Name: _____

Academic Rank: _____

Institution: _____

Department: _____

Date: _____

Course /Lecture/Laboratory/Seminar Information

Course Number: _____

Title of course: _____

Student grade in course: _____

Evaluator Signature: _____

Mail completed form to: School of Medical Technology
Inter American University of PR
Metropolitan Campus, PO Box 191293
San Juan, PR 00919-1293