



Inter American University of PR
 Metropolitan Campus
 Science and Technology Faculty
 Department of Medical Technology
Recommendation Letter Form

Applicant Name: _____

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

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

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 follows instructions, reaches reasonable conclusions, can problem solve, and rapidly adapts 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: Dept of Medical Technology
 Inter American University of PR
 Metropolitan Campus, PO Box 191293
 San Juan, PR 00919-1293