Summer Medical and Dental Education Program
Recommendation Form
Summer 2008

To the applicant: This section is to be completed by the applicant before giving it to the individual providing the recommendation:

Applicant's SMDEP ID Number: ______________________

Applicant's Social Security Number/Alternate ID Number: ______________________

Applicant's Name: ______________________
Last First Middle Suffix

Applicant's Address: ______________________

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Applicant's Phone Number: (   ) ______________________

Applicant's E-mail Address: ______________________

To the Prehealth Advisor and/or College Professor:

Please answer as many questions as your acquaintance with the student permits. You may submit a letter in addition or in substitution of this form, but it is **imperative** that this page accompany any recommendation to properly match documents to files.

Your recommendation should be mailed to the SMDEP National Program Office:

Summer Medical and Dental Education Program
Division of Diversity Policy and Programs
Association of American Medical Colleges
2450 N Street, NW
Washington, DC 20037-1127
ATTN: Recommendations

If you have questions about this form, please contact the SMDEP National Program Office at 1(866)58-SMDEP (toll free) or e-mail smdep@aamc.org.

07/2004

SMDEP is a national program funded by the Robert Wood Johnson Foundation with direction and technical assistance provided by the Association of American Medical Colleges and the American Dental Education Association.

Please rate the applicant by circling the appropriate number which most nearly represents your opinion of the applicant in comparison with a representative group of individuals you have known who have had the same amount of education and experience.

	Unable to Judge	Poor	Fair	Good	Outstanding
Intellectual ability	0	1	2	3	4
Integrity	0	1	2	3	4
Work habits	0	1	2	3	4
General motivation	0	1	2	3	4
Leadership	0	1	2	3	4
Imagination/Creativity	0	1	2	3	4
Initiative	0	1	2	3	4
Ability to work with others	0	1	2	3	4
Maturity	0	1	2	3	4
Ability to communicate (written)	0	1	2	3	4
Ability to communicate (spoken)	0	1	2	3	4

In what capacity do you know the applicant? ____________________

Do you have any concerns about this student's ability to participate in an intensive 6-week residential program designed to increase his/her preparedness for application to medical or dental school.

☐ I have no concerns

☐ I have concerns about this student

Please provide any additional information that would be helpful to SMDEP Programs.

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REFERENCE INFORMATION
(Please Print)

Name: ____________________

Title/Position: ____________________ Department: ____________________

Name of College/University: ____________________

Address: ____________________

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Phone: ( ) -- ____________________ Email Address: ____________________

Signature: ____________________ Date: ____________________