

# CONFIDENTIAL STATEMENT OF RECOMMENDATION FOR RADIOGRAPHY CERTIFICATE PROGRAM

**Complete and return to: School of Radiography, University Hospital, 1350 Walton Way, Augusta, GA 30901-2612**

**TO THE CANDIDATE:** By signing below you are waiving your right to read the recommendation

**CONFIDENTIAL: Not Subject to My Review**  
 I request that my reference complete this recommendation form. Your candid evaluation of me and information from school records is being sought and will be held in strict confidence both from me and the public by the Stephen W. Brown School of Radiography.

\_\_\_\_\_

Applicant's Name (please print) Date

**Applicant: Complete the following section**

\_\_\_\_\_

Applicant Name Address

\_\_\_\_\_

Reference Name Address

The Family Education Rights & Privacy Act, as amended, allows an individual to waive the right to view confidential recommendations. The individual named above has waived that right and **this recommendation will be confidential.**

**REFERENCE:** Complete the following section: **(please answer all questions)**

**1) In what capacity have you been acquainted with the applicant and for what length of time?**

**2) Please check the following as it applies to the applicant**

	Low-third	Mid-third	High-third	N/A
<b>a) Motivation</b> Shows an interest in learning; has a desire to excel				
<b>b) Perseverance</b> Persistent and consistent in efforts to achieve				
<b>c) Ability to get along with others</b> Works well with others; courteous and cooperative				
<b>d) Attitude toward criticism</b> Learns from mistakes; receptive to suggestions				
<b>e) Emotional stability</b> Exercises self-control; maintains composure in difficult situations; adjusts to change				
<b>f) Maturity</b> Accepts responsibility; dependable; respectful				

**Do you recommend the applicant for entry into the profession of radiologic technology?**

- Not recommended  **Comments:**
- Recommended with reservations
- Recommended with confidence
- Recommended enthusiastically

\_\_\_\_\_

Reference Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Position/Title

\_\_\_\_\_

Phone Number (for further clarification if necessary)

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Please  
place  
stamp  
here.

UNIVERSITY HOSPITAL  
SCHOOL OF RADIOGRAPHY  
1350 WALTON WAY  
AUGUSTA GA 30901-2612

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