UCI School of Medicine

Phone: 949-824-0272 E-mail: MedAcademy@uci.edu

UCI MedAcademy

Teacher/School Counselor Recommendation Form

Applicant's Name: _____ Date: _____
(Please print legibly.)

Name of School Attending: _____

Applicant: Please ask your teacher or school counselor to complete this form and send it directly to us at MedAcademy@uci.edu. The completed form must be sent from a teacher or counselor's school-sponsored email account by the application deadline in order for your application to be considered complete.

Dear Evaluator:

Please evaluate the above applicant in relation to other students at the same level of learning.

How well do you know this applicant? (Please include length of time and your association.)

_____

_____

_____

_____

_____

_____

Outstanding=top 10% Good=top 25% Average=50% Poor=bottom 10%

Rating of Characteristics	Outstanding	Good	Average	Poor	No opinion
Motivation					
Dedication					
Reliability					
Self-Confidence					
Maturity					
Written Expression					
Communication					
Interpersonal Relationships					
Intelligence					
Leadership Capability					

Other comments or concerns (attach additional pages if needed):

Overall recommendation: Strongly recommend _____ Recommend _____ Do not recommend _____

Name of Evaluator (Please print legibly): _____

Signature: _____ Date: _____

Evaluator's e-mail address: _____ Phone: _____

School Name: _____

School Address: _____

Please E-mail this completed form to: MedAcademy@uci.edu
Please note: This student evaluation form must be sent from a teacher or counselor's school-sponsored email account by the application deadline in order to complete the student's application.

Additional information is available on our website: http://www.meded.uci.edu/medical-academy/