Peconic Bay School of Radiologic Technology
Classroom: 4 West Second Street, Lower Level, Riverhead, New York 11901
Mailing Address: 1300 Roanoke Avenue, Riverhead, New York 11901
(631) 548-6173
Email: xrayschool@pbmchealth.org

Name of Applicant (Print Clearly): _____

Name of Reference (Print Clearly): _____

_____ I am this applicant's employer/supervisor.

_____ I am this applicant's instructor/professor or former instructor/professor.

_____ This applicant has worked under my supervision from _____ to _____.

TO THE APPLICANT: Fill in the information above. For the convenience of your reference, please include a SELF-ADDRESSED STAMPED ENVELOPE with this form. Your reference should return their LETTER OF RECOMMENDATION to you to include in your application packet.

In accordance with the provisions of the Family Educational Rights and Privacy Act of 1974, P.L. 93 – 390 (as amended), with specific reference to Section 438 (a)(1)(B) and Subtitle A, sections 99.7, 99.11, and 99.12,

I do _____ I do not _____ waive my right to access to and review of this form.

_____ _____
Signature of Applicant Date

TO THE REFERENCE: The applicant named above is applying for admission to Peconic Bay School of Radiologic Technology. We are interested in obtaining information that will aid us in selecting capable students. It is important that students who are selected be able to complete their academic work successfully, and also possess the personal qualifications essential to become competent professionals. PLEASE COMPLETE BOTH PAGES!

The applicant has selected you as someone who can give us such as appraisal. We would appreciate your candid evaluation of the applicant's qualifications for acceptance to the program. ***The pending application will be considered incomplete until your response is received.***

1. **PERSONAL & PROFESSIONAL APPRAISAL:** (Please evaluate the applicant's qualifications and characteristics by checking the appropriate spaces below.)

Qualifications/Characteristics	SUPERIOR	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE	N/A
Intellectual Ability					
Reliability					
Sense of Responsibility					
Industry & Perseverance					
Ability to Work Independently					
Ability to Adapt to New Situations					
Ability to Work With People					
Ability to Analyze Problems & Solve Them Correctly					
Oral Communication					
Written Communication					
Emotional Stability					
Leadership Potential					

TO THE REFERENCE: In addition, please complete the following information.

2. **ACQUAINTANCE WITH APPLICANT**: How long and in what capacity have you known this applicant?

   _____

   _____

3. **COMMENTS**: In the space below (use an extra sheet if needed), please add any descriptive comments that will aid in providing a complete picture of the applicant's abilities and potential as a student and health care professional.

   _____

   _____

   _____

   _____

   _____

   _____

4. **RECOMMENDATION FOR ACCEPTANCE**:

   _____ Strongly Recommend _____ Recommend

   _____ Recommend with Reservations _____ Do Not Recommend

PLEASE TYPE OR PRINT

Your Name: _____ Professional Credentials: _____

Title: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Date: _____ Signature: _____

PLEASE NOTE: It is not possible to thank each individual personally for completing a recommendation form. We want you to know, however, that we are aware of the time required and both we and the applicant are most appreciative of your response.

If attaching a separate Letter of Recommendation, please state on this form in #3-Comments, but please do complete the #1-Personal & Professional Appraisal on page 1.