



TO BE COMPLETED BY APPLICANT

Name of applicant _____

Address _____

Street

City/State

Zip

Home Phone () _____ Work Phone () _____

Option applying for: Nurse Practitioner Adult Family Health Care Systems Management

Name of recommender _____

OPTIONAL WAIVER OF RIGHTS:

I hereby waive my right to have access to this evaluation form when completed, and understand that this confidential recommendation is to be used only in consideration of my application to the Loyola University New Orleans Master of Science in Nursing program.

Applicant's Signature

Date Mailed to Recommender by Applicant

TO THE RECOMMENDER:

The person whose name appears above is applying for admission to the Master of Science in Nursing program at Loyola University New Orleans. Your assistance is requested in providing information which the Admission Committee will use to evaluate this applicant.

How long have you known the applicant? _____

In what capacity have you known the applicant? _____

Please rate the applicant on the following criteria:

	Superior	Good	Average	Poor	Don't Know
Analytical Thinking					
Communication Skills					
Motivation					
Imagination / Creativity					
Maturity / Independence					
Ability to Collaborate					
Clinical Nursing Skills					

1. What do you consider the candidate's most outstanding talents or characteristics?

2. Do you feel graduate study is appropriate for the applicant at this time?

Please indicate the strength of your recommendation of this applicant for the Loyola University Nursing Graduate Program:

CHECK ONE

- I strongly recommend
- I recommend
- I recommend with some reservations
- I do not recommend

Signature

Date

PLEASE PRINT:

Name _____ Title / Position _____

Address: _____
Street City / State Zip

RETURN TO GRADUATE ADMISSIONS, NURSING DEPARTMENT:

6363 ST. CHARLES AVENUE, BOX 14 • NEW ORLEANS, LOUISIANA 70118 • Phone: 504-865-3142 • Fax 504-865-3254