

Evaluation Form for Chesapeake College ADN Scholarship

to accompany your Letter of Recommendation

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial \_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Academic Year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Program of Study/Degree \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Applicant: Please respond to this statement.**

I agree that the recommendation I am requesting shall be held in confidence by officials of UM Memorial Hospital Foundation and I hereby waive any Rights I may have to examine it. \_\_\_\_\_ Yes \_\_\_\_\_ No

**Recommender**

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position/Affiliation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip/Postal Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Professional Website\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of Time Affiliated with Applicant\_\_\_\_\_\_\_\_\_ Affiliation with Applicant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Evaluation**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Below  Average  (Lowest 40%) | Average (Middle 20%) | Above  Average  (Next 25%) | Unusual (Next 5%) | Outstanding  (Almost Top 5%) | Truly  Exceptional  (Top 5%) | Inadequate  Opportunity to Observe |
| Intellectual Potential |  |  |  |  |  |  |  |
| Ability to Work with Others |  |  |  |  |  |  |  |
| Creativity, Imagination |  |  |  |  |  |  |  |
| Maturity |  |  |  |  |  |  |  |
| Communication: Oral |  |  |  |  |  |  |  |
| Communication: Written |  |  |  |  |  |  |  |
| Analytical and Problem-Solving Skills |  |  |  |  |  |  |  |
| Potential as a Nurse |  |  |  |  |  |  |  |
| Demonstrates a Professional Image |  |  |  |  |  |  |  |
| Completes Tasks in a Timely Manner |  |  |  |  |  |  |  |
| Demonstrates Flexibility |  |  |  |  |  |  |  |
| Good Attendance Record |  |  |  |  |  |  |  |
| Demonstrates Leadership Skills |  |  |  |  |  |  |  |
| Good Problem Solver |  |  |  |  |  |  |  |
| Strength of Overall Endorsement |  |  |  |  |  |  |  |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return form along with your Letter of Recommendation to: UM Memorial Hospital Foundation, Scholarship Program, PO Box 1846, Easton, MD 21601

Effective date: 06/08/2023