

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