REFERENCE FORM

SEND WITH APPLICATION

NAME OF APPLICANT

ADDRESS

STATE  ZIP CODE

AGREEMENT RESPECTING CONFIDENTIALITY

I waive _____ I do not waive _____ my right of access to this recommendation form under the Family Educational Rights and Privacy Act of 1974. I understand that this form will be used by the School solely in its procedures relating to admissions.

Signature of Applicant

Date

Name of Reference

Address

State  Zip Code

*** IMPORTANT ***

APPLICANT TO COMPLETE THE ABOVE INFORMATION AND SEND WITH APPLICATION. THE SCHOOL WILL MAIL THE ABOVE FORM TO THE REFERENCE PERSON. A TOTAL OF 2 REFERENCE FORMS ARE REQUIRED ALONG WITH YOUR APPLICATION.

NOTE:  It would be of assistance to the Admissions Committee if you would give your candid evaluation of the above named applicant. We are aware that we are asking for considerable time and effort on your part in completing this form. We want to assure you that your generous assistance in giving this appraisal will be appreciated.

TO THE PERSON COMPLETING THIS FORM:

The above named individual is applying for study at Christ Hospital School of Radiography. The Program attaches great importance to the testimony of faculty members and others qualified to make judgments of the applicant.

DO NOT COMPLETE THIS FORM IF THE SECTION ABOVE HAS NOT BEEN COMPLETED AND SIGNED.

How long have you known the applicant? ____________

in what capacity? ____________

(PLEASE RATE THE APPLICANT TO THE BEST OF YOUR ABILITY)
## REFERENCE FORM

<table>
<thead>
<tr>
<th>ACADEMIC/PROFESSIONAL PERFORMANCE</th>
<th>POOR</th>
<th>FAIR</th>
<th>AVERAGE</th>
<th>ABOVE AVERAGE</th>
<th>NOT ABLE TO JUDGE</th>
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<td>Competence in written work</td>
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<td>Skill in oral expression</td>
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<td>Creativity in research work, projects, etc.</td>
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<td>Motivation for school study</td>
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<td>Preparation for school work</td>
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<td>Ability to work independently</td>
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<td>Personality</td>
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<td>Ability to get along with others</td>
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<td>Mental Alertness</td>
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## PERSONAL IMPRESSION/REMARKS:

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
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__________________________________________________________________
__________________________________________________________________

Recommender’s Name ______________________________ Date ____________

Position or Title ______________________________ School/Business _______________________

Address __________________________ City __________________________ State ______ Zip Code ________

Signature __________________________

RETURN TO: Administrative Assistant  
Christ Hospital  
School of Radiography  
176 Pelissade Avenue  
Jersey City, New Jersey 07306