Skyline College
Achieve.

PERSONAL REFERENCE FORM
Surgical Technology Program

Applicant's Name

Recommender's Name

Applicant: Under federal law entitled "Family Educational Rights Act of 1974" students are given the right to inspect their records including letters of recommendation. All letters of recommendation are considered carefully. Letters written in confidence are useful in the assessment of a student's qualifications and abilities.

A signature is required for either A or B.
By signing A, your recommender knows the evaluation will be submitted in confidence.
By signing B, you have retained the right to inspect this letter of reference.

A. I waive my rights to inspect this letter of reference and hereby inform my recommender that this letter will be kept strictly confidential.

Applicant's Signature

B. I retain my right to inspect this letter of reference. Recommender is advised that upon enrollment I may have access to this letter.

Applicant's Signature

Recommender: You have been requested to complete a reference form for an applicant to the Surgical Technology Program. Your objective appraisal will assist in evaluating the applicant's qualifications. Please return the form to the address on the back. If you do not wish to evaluate the applicant, please check item #6 and return the form. The application deadline is April 1st. Thank you for your time and assistance.

1. In what capacity and for how long have you known the applicant?

2. Describe observed strengths and weaknesses and evidence of maturity or immaturity.

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3. Do you have reason to believe the applicant has realistic professional goals?

4. Please describe any personal, physical, or emotional characteristics that may be important to the applicant's success in this profession.

5. How would you rate the applicant as a candidate for the Surgical Technology Program? If you have reservations, please explain.

- ☐ Highly recommended
- ☐ Recommended
- ☐ Some reservations
- ☐ Serious reservations
- ☐ I cannot adequately evaluate this candidate and would prefer the candidate seek a recommendation from another individual.

Recommender's signature: _____

Address: _____

Title/ position: _____

Please return this form to:

Allied Health Program Services Coordinator at **ranades@smccd.edu**

APPLICATIONS ARE DUE MAY 1