

Doctor of Nursing Practice Program Recommendation



Ida V. Moffett School of Nursing
Samford University

Applicant Information (This portion must be completed by the applicant. Please print legibly or type.)

Name _____
Last First Middle

Address _____
Street/Box Number City State Zip

Advanced Practice Foci (Specialization)

- Advanced Practice Nursing:** For students with an M.S.N. degree and certified as a Clinical Nurse Specialist, Nurse Anesthetist, Nurse Midwife or Nurse Practitioner. Current Practice Area Certified _____
- Administration:** For students with an M.S.N. degree and a career goal to practice as a Nurse Executive in either a Health Care Delivery System or School of Nursing
- Education:** For students with an M.S.N. degree and a career goal to acquire knowledge and skills as a Nurse Educator

Name of Person Providing Reference _____
Last First Middle

Type of Reference Academic Professional

The Family Education Rights and Privacy Act of 1974 entitles School of Nursing graduate applicants to have access to letters of evaluation. Applicants should understand that the individual completing this form is likely to be more candid if they know their comments are confidential. If you wish to waive your right to access this letter of evaluation, please sign your name on the line below the following statement.

- I do not waive my rights or privileges provided by Public Law 93-380 to inspect or challenge the content and comments appearing in this letter of evaluation.
- I, the undersigned, hereby waive all rights or privileges provided by Public Law 93-380 to inspect or challenge the content and comments appearing in this letter of evaluation.

Applicant's Signature _____

Date _____

Reference Information

This portion must be completed by the person providing the reference. Please complete the information requested on both sides of this form. Use additional pages if necessary. Return your recommendation in a **sealed envelope with your signature across the back flap** to the applicant. Your comments will be held completely confidential if the applicant has signed the statement above.

Please describe your relationship to the applicant and how long you have known the applicant.

What do you consider to be the applicant's strengths?

What do you consider to be the applicant's weaknesses?

Describe your relationship with the applicant (situation, setting and length) and observations of effective and ineffective professional and personal behavior.

Qualifications

Please check the appropriate box:

Table with 6 columns: Qualification, Outstanding Top 5%, Above Average Top 25%, Average Top 50%, Below Average, No opportunity to observe. Rows include Motivation, Leadership capability, Resourcefulness, Judgement and professional maturity, Ability to collaborate, Breadth of general knowledge, Intellectual capacities, Emotional stability, Quality of oral expression, Analytical ability, Quantitative ability, Expertise in practice specialty.

Overall evaluation of applicant: [] Strongly Recommend [] Recommend [] Recommend with Reservation [] Do Not Recommend

Please comment on the ratings you have assigned and make additional comments about the applicant's record, potential, personal or leadership qualities that you feel would be helpful to the Graduate Admission Committee. The committee is interested especially in anything that would not otherwise be apparent in the applicant's record.

Name (Please print.) _____
Last First Middle

Position or Title _____

Business Address _____
Street/Box Number City State Zip

E-mail Address _____ Daytime Phone _____

May faculty contact you for further questions? [] Yes [] No

If yes, what is your preferred method? [] Daytime Phone [] E-mail [] Other _____

Signature of Person Providing Reference

Date