CONFIDENTIAL REPORT ON CANDIDATE SEEKING ADMISSION FOR ADVANCED CLINICAL TRAINING PROGRAM OR PRECEPTORSHIP

Name of Applicant:_____
(Last) (First)

Name of Program:_____

NOTE TO RESPONDENTS: You have been selected as a reference by the above named applicant who wishes to pursue a course of Postgraduate study in the Preceptorship Program. Your cooperation in completing this inquiry and mailing to the address below will be appreciated.

GENERAL IMPRESSION	EXCELLENT	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Professional attitude				
Habits and manners				
Poise				
Speech				
Honesty/ethics				
Appearance, neatness, care with personal image				
Social attitude and ability to get along with people				

PERSONALITY: _____Outgoing _____Average _____Quiet _____Other: _____

MATURITY: _____Mature _____Will Mature Well _____Good _____Average _____Poor

Comment:_____

ETHICS: _____Excellent _____Recommend _____Average _____Other: _____

Comment:_____

PROFESSIONAL ABILITIES	EXCELLENT	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Academic skills				
Clinical knowledge				
Clinical performance				
Patient relations				
Student relations				
Faculty relations				

MOTIVATION: _____ Makes strong, independent decisions _____ Average desire and intentions
_____ Casual/adequate _____ Unusual, outside influence

Comment:_____

INDUSTRY: _____ Works at capacity _____ Works well, has reserve capacity
_____ Average _____ Satisfactory work, not always best

Comment:_____

COMMUNICATION	IMPAIRED BY SPEECH OR PHYSICAL DEFECT	POOR EXPRESSION	VERBOSE	ACCURATE/ APPROPRIATE
Oral				
Written				

In addition to the ratings you have provided, please add any special observations or comments which might be of value in considering this applicant's admission to a course of advanced study:

I have been acquainted with this applicant for approximately _____ (yrs., mos.) in the capacity of _____. (Teacher, Advisor, Colleague)

Based upon my contact and knowledge of this applicant he/she would rank _____ in the class of _____ students..

1. My recommendation is :

_____Strong _____Good _____ Adequate

2. _____I do not recommend

AFTER SIGNING AND SEALING IN EVELOP
Please mail to:
ACT & Preceptor Programs
Office of Student Affairs
UCLA School of Dentistry
Box 951668, Room A0-111 CHS
Los Angeles, CA 90095-1668 USA

If you wish to use a courier service please use this address:
ACT & Preceptor Programs
Office of Student Affairs
UCLA School of Dentistry
Room A0-111 CHS
650 Charles E. Young Drive South
Los Angeles, CA 90095-1668

Name:_____

Signature:_____

Title:_____

Address:_____

_____

Date:_____