Health Professions Advisory Committee Evaluation Form

State University of New York College at Old Westbury

Applicant Section: This section to be completed by the **applicant.**

1. Name: _____ _____ _____
   Last or Family First Middle

2. Type of school applying to: [ ] Medical [ ] Osteopathic Medical [ ] Dental
   [ ] Podiatry [ ] Optometry [ ] Other _____

3. Affidavit of Waiver (Optional): In accordance with the Family Educational Rights and Privacy Act of 1975, as amended, I waive my right of access to this evaluation requested by the Health Professions Advisory Committee to be used in formulating recommendations concerning my applications to schools of the type indicated above.

_____ _____
Applicant's Signature Date

If left unsigned, you will have access to this document after it is completed and returned to the committee. This will not affect the committee's consideration of your application in any way.

Reference Section: This section to be completed by the **recommender.**

The applicant has indicated above whether access to this evaluation has been waived. We appreciate your cooperation. Please remember to **sign the form on the reverse side**. Please DO NOT return this form to the applicant.

Please mail this form to: Health Professions Advisory Committee
SUNY College at Old Westbury
NSB Room S247A
223 Store Hill Road
Old Westbury, NY 11568-0210

How long have you known this applicant? _____ In what capacity? _____

Please evaluate the applicant for the following qualities using the indicated scale:

Area of Evaluation	Outstanding (Top 10%)	Above Average (Next 15%)	Average	Below Average	Not Observed
Intellectual Ability					
Originality					
Writing Skills					
Verbal Skills					
Motivation					
Independence					
Leadership					
Reliability					
Integrity					
Maturity					
Relations with others					

(Please continue on reverse side)

In the space below, or in a separate letter, please add any comments that will assist the Health Professions Advisory Committee in developing an overall assessment of the applicant's suitability for a health career. Please include a description of any areas in which the applicant has demonstrated excellence and comment on his or her motivation to serve as a health care professional.

Signature _____ Date _____

Name and Title (print or type) _____

Institution _____ Department _____

Address _____ E-mail _____

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