FLORIDA HOSPITAL
COLLEGE OF HEALTH SCIENCES
FHCHS Off-Site Admissions Center • 2145 Metro Center Blvd., Suite 400 • Orlando, FL 32835 • Fax (407) 395-0017 (BSN) / (407) 395-0016 (BSRS/BSDMS)

Distance Recommendation Form

Please use black or blue ink only when completing this form.

TO BE COMPLETED BY THE APPLICANT

Applicant's Name: (please print) Student ID:

Department of Interest:

❑ Diagnostic Medical Sonography ❑ Nursing ❑ Radiologic Sciences

APPLICANT'S WAIVER OF RIGHT OF ACCESS TO CONFIDENTIAL STATEMENT:

❑ I waive my right of access to any information contained on this recommendation form.

❑ I do not waive my right to access any information contained on this recommendation form.

Applicant's Signature (Required) _____ Applicant's Phone Number _____ Date _____

TO BE COMPLETED BY THE EVALUATOR

Florida Hospital College of Health Sciences, a Seventh-day Adventist institution, specializes in the education of healthcare professionals. The College provides an environment where students can develop spiritually, intellectually, socially, and physically while pursuing professional expertise integrated with Christian values. Our vision – Nurture, Excellence, Spirituality, Stewardship – is central at FHCHS and our goal is to teach healthcare as ministry. In your opinion, would this applicant be a good fit at FHCHS considering our mission and vision? ❑ Yes ❑ No

In light of the mission statement above, please assess this applicant using the scale below. We value your comments and ask that you give a full and candid appraisal so that fair consideration may be given the applicant. Please circle the appropriate number.

5 = Outstanding 4 = Good 3 = Average 2 = Fair 1 = Poor 0 = No basis for evaluation

Academic motivation	5	4	3	2	1	0	Ability to cope with stress	5	4	3	2	1	0
Attitude toward authority	5	4	3	2	1	0	Analytical and problem-solving skills	5	4	3	2	1	0
Adaptability to change	5	4	3	2	1	0	Ability to work independently	5	4	3	2	1	0
Organizational skills	5	4	3	2	1	0	Ability to work with people	5	4	3	2	1	0
Integrity	5	4	3	2	1	0	Leadership ability	5	4	3	2	1	0
Dependability/Reliability	5	4	3	2	1	0	Professional appearance	5	4	3	2	1	0
Emotional maturity	5	4	3	2	1	0	Ability to communicate effectively	5	4	3	2	1	0
Timeliness	5	4	3	2	1	0	Clinical skills (if applicable)	5	4	3	2	1	0

I have known the applicant for:

❑ Less than a year

❑ 1-3 years

❑ 3 or more years

My relationship to the applicant is/has been:

❑ Employer/Supervisor

❑ Educator

❑ Counselor

❑ Other _____ (Family & friends not permitted)

My statement is:

❑ I recommend the applicant without reservation.

❑ I recommend the applicant with reservation. (Please explain)

❑ I cannot recommend the applicant at this time. (Please explain)

COMMENTS

We invite additional comments and observations about the applicant.

EVALUATOR INFORMATION

Name:

Place of Employment:

Position:

Address:

Telephone: Work: ( ) Home: ( )

_____ Signature _____ Date

Thank you for your time and information. An applicant may be considered for program admission when this completed recommendation form is returned to FHCHS. This form may be mailed or faxed.