RECOMMENDATION REQUEST FOR DRUG INFORMATION
RESIDENCY APPLICATION

APPLICANT'S NAME: _____

_____ I waive the right to review this recommendation.

_____ I do not waive the right to review this recommendation.

_____ _____
Applicant Signature Date

REFERENCE:

Name: _____ Title: _____

Institution: _____

_____
Mailing Address

_____ _____ _____
City State Zip

Phone: _____ E-Mail: _____

Attach a letter of recommendation that addresses the following points:

- How well and in what capacity do you know the applicant?
- How does this applicant rate with regard to others with similar training (e.g., among best, average, among worst)?
- What special strengths do you feel the applicant possesses?
- How would you evaluate the candidate's communication skills (verbal & written) and interpersonal skills?
- Are there any areas of weakness that must be addressed?
- Do you believe the applicant will be successful in this residency? Why or why not?

Please complete and return by February 5. Thank you.

Return To: Marie A. Abate, PharmD
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