UNIVERSITY of WISCONSIN
LA CROSSE

Department of Health Professions
Medical Dosimetry Program

LETTER OF RECOMMENDATION FORM

Name of Applicant: _____

Name of Reference: _____

To the applicant:

Please have this form filled out by a professional reference of your choice, following the guidelines on the application.

You will submit your recommendation requests using the Applicant Dashboard. You will need the name and email address for each reference. Be sure to let your references know when to look for an email from UWL requesting your recommendation letter.

To the Reference:

The individual named above has applied for admission to the Medical Dosimetry Program at the University of Wisconsin – La Crosse.

We are interested in obtaining information that will assist the admissions committee in assessing this individual's characteristics and aptitude for medical dosimetry. It is important that the students selected be able to complete the academic work successfully as well as possess personal qualifications essential for competent professional performance in medical dosimetry.

Acquaintance with applicant - How long and in what connection have you known this applicant?

Please rate the applicant in the following categories, using a scale of 1 to 5 with five being superior and one being poor. Please check N/A if you are not able to evaluate.

Characteristics	Superior 5	4	3	2	Poor 1	N/A
Academic Potential						
Leadership Skills						
Mathematics & Computer Skills						
Reliability						
Oral Communication Skills						
Written Communication Skills						
Organizational Skills						
Ability to work independently						
Adaptability						
Problem Solving Skills						
Ability to work with people						
Responsibility						

Recommendation

( ) Strongly Recommended
( ) Recommend with Reservations
(please explain in comment section)
( ) Recommend
( ) Do Not Recommend
(please explain in comment section)

Comments

Please add any descriptive comments that will aid in providing a complete overview of the applicant's abilities and potential as a student and medical dosimetrist. Use an additional sheet if necessary.

Name _____ Title _____

Organization _____

Street Address _____

City _____ State _____ Zip Code _____

Work phone number ( ) _____

Signature _____ Date _____