THE UNIVERSITY OF ALABAMA | College of Arts & Sciences
Office of Health Professions Advising

REQUEST FOR A LETTER OF RECOMMENDATION
CYCLE 2019

THIS SECTION IS TO BE COMPLETED BY THE STUDENT/APPLICANT:

STUDENT'S NAME: _____UA CWID:_____

STUDENT'S EMAIL:_____@crimson.ua.edu

HOW DO YOU KNOW THIS EVALUATOR? _____
(Professor, Physician I shadowed, Extracurricular/Work Supervisor, etc.)

If Applicable:

Course(s) taught: _____Semester/Year: _____Grade: _____

I hereby voluntarily __waive __do not waive access to this confidential evaluation:

_____ _____
Student Signature Date

- ☐ MEDICAL
- ☐ DENTAL
- ☐ OPTOMETRY

It is strongly recommended that you choose to waive your right to view your letters.
*Give letter writers **at least two weeks** to complete your letter. If you have questions, please ask.*

TO THE EVALUATOR: **Requested Submission Date: ____/____/____**

The Health Professions Advising Committee will use the information you provide to write a composite recommendation of the above named student to medical, dental, or optometry school, and send a copy of your letter to the professional schools. All letters must be on **LETTERHEAD, DATED, AND SIGNED**. Letters should be addressed to "**Dear Admissions Committee.**"

Do you think he/she has performed at or below his/her potential? Do you think the academic record and test scores of this student are a good indication of his/her potential in the health professions? If not, please specify the qualities or circumstances of the student that would help put such quantitative measurements in better perspective.

Interpersonal Competencies
Social Skills
Cultural Competence
Teamwork
Oral Communication

Intrapersonal Competencies
Ethical Responsibility to Self and Others
Reliability and Dependability
Resilience
Capacity for Improvement

Thinking and Reasoning Competencies
Critical Thinking
Quantitative Reasoning
Scientific Reasoning
Written Communication

Science Competencies
Living Systems
Human Behavior

Please specify your summary recommendation by indicating from the choices below. ***Your recommendation should be based on the applicant as compared to other pre-health professional students with whom you have worked.***

Top Quartile	**Second Quartile**	**Third Quartile**	**Bottom Quartile**	**No Recommendation**

EVALUATOR SIGNATURE: _____ DATE: _____

TITLE/DEPARTMENT/CONTACT PH#:_____
(Attach business card if possible)

PLEASE RETURN THIS FORM AND YOUR LETTER TO:
HEALTH PROFESSIONS ADVISING
BOX 870268
TUSCALOOSA, AL 35487-0268

OR SEND AS AN EMAIL ATTACHMENT TO: PREHEALTHRECS@UA.EDU

Professional schools will not accept letters that are not signed and on department letterhead.
Questions? Call (205) 348-5970