

**Recommendation Request - Applicant to Pharmacy Residency Program
University of Iowa Hospitals and Clinics**

To be completed by applicant (please type or print):

Name of Applicant: _____

First Name	Initial	Last Name
Street address or P.O. Box		Telephone Number
City	State	Zip

I waive the right to review this recommendation _____
Signature of Residency Applicant

<input type="checkbox"/> PGY1 Pharmacy Residency	<input type="checkbox"/> PGY1 Pharmacy Residency, Ambulatory Care focus track <input type="checkbox"/> PGY2 Ambulatory Care Residency
Trisha A. Smith, Pharm.D. Program Director, PGY1 Pharmacy Residency University of Iowa Hospitals and Clinics Department of Pharmaceutical Care 200 Hawkins Drive, CC101 GH Iowa City, IA 52242-1009 (319)356-2577, trisha-a-smith@uiowa.edu	Deanna L. McDanel, Pharm.D., BCPS Program Director, PGY2 Ambulatory Care Residency Coordinator, PGY1 Residency - Ambulatory Care track University of Iowa Hospitals and Clinics Department of Pharmaceutical Care 200 Hawkins Drive, CC101 GH Iowa City, Iowa 52242-1009 (319)384-5901, deanna-mcdanel@uiowa.edu

To the recommender: *Please complete and return this form by January 6, 2012*
***Attaching a written letter of recommendation in addition to this form is preferred**

Applicants to the residency program specified above are required to have recommendations submitted by persons who are in a position to evaluate their qualifications for residency training. The recommender is asked to make a frank appraisal of the applicant's character, personality, abilities, and suitability for a pharmacy residency. **All comments and information provided will be kept in strictest confidence.**

For the recommender to complete:

I have known the applicant for approximately _____ (months) (years). My relationship to the applicant was (or is) in the following capacity

_____ faculty advisor	_____ employer
_____ clerkship preceptor	_____ supervisor
_____ other faculty relationship	_____ other (please specify) _____

I know him/her _____ very well _____ fairly well _____ only casually

Relative to persons of similar background, training, and professional interests, please rate this applicant for each of the following characteristics:

CHARACTERISTICS EVALUATED	UPPER 10%	UPPER 25%	UPPER 50%	LOWER 50%	NO BASIS FOR JUDGMENT
Academic ability					
Quality of work					
Written communication skills					
Oral communication skills					
Leadership skills					
Industriousness and perseverance					
Initiative and motivation					
Assertiveness					
Cooperativeness					
Ability to organize and manage time					
Ability to work with supervisors					
Ability to work with peers					
Ability to work with patients					
Dependability					
Resourcefulness and originality					
Willingness to accept criticism					
Personal appearance and demeanor					
Commitment to professional practice					
Emotional stability and maturity					
Enthusiasm					
Integrity					

Does the applicant possess any special assets which should be noted?

Does the applicant demonstrate any weaknesses which you feel would hinder his/her ability to perform effectively in a residency program?

Other comments:

Recommendation concerning admission (check one):

I highly recommend this applicant I recommend this applicant, but with some reservation

I recommend this applicant I am not able to recommend this applicant

Signature of Recommender

Date

Name-typed or printed

Title and Affiliation

Street address or P.O. Box

City

State

Zip

Telephone Number

**Adapted from the American Society of Health System-Pharmacists
Standardized Residency Applicant Recommendation Request Form**