

OKLAHOMA SCHOOL OF MEDICAL TECHNOLOGY/CLINICAL LABORATORY SCIENCE

STUDENT EVALUATION FORM

NAME OF STUDENT (Please print name in full): _____

I. SCHOLASTIC ABILITY

A. Where would you rank this applicant with those currently in your department/class? Please indicate ranking criteria: class () department () other ()

LOWER 1/3 () MID 1/3 () UPPER 1/3 ()

B. In your opinion, is the applicant's scholarship record an accurate index?

YES () NO () DON'T KNOW ()

ADDITIONAL COMMENTS:

II. PERSONAL APPRAISAL

A. How long have you known this applicant? _____

In what capacity? _____

B. Rate the applicant on the following qualifications, in comparison to other students in classes. (5 = Outstanding; 3 = Average; 1 = Poor)

5	4	3	2	1		Not Observed
_____	_____	_____	_____	_____	Laboratory skills/dexterity	_____
_____	_____	_____	_____	_____	Sense of responsibility	_____
_____	_____	_____	_____	_____	Cooperation with others	_____
_____	_____	_____	_____	_____	Ability in written expression	_____
_____	_____	_____	_____	_____	Ability in oral expression	_____
_____	_____	_____	_____	_____	Maturity and emotional stability	_____
_____	_____	_____	_____	_____	Motivation for med tech career	_____

C. Overall recommendation:

_____ Highly Recommended

_____ Recommended with Reservations

_____ Recommended

_____ Not Recommended

NAME: _____

TITLE: _____

SIGNATURE: _____

DATE: _____

INSTITUTION: _____

**PERMISSION TO RELEASE PERSONALLY IDENTIFIABLE AND/OR
WAIVER OF RIGHT TO INSPECT OR REVIEW CONFIDENTIAL LETTER OF RECOMMENDATION
(FAMILY EDUCATION RIGHTS AND PRIVACY ACT OF 1974, AS AMENDED)**

I, _____, () do () do not hereby waive and renounce all right of access, including those established by the Family Education Rights and Privacy Act of 1974, to any letter or letters of reference or confidential letters of recommendation to be hereafter written in my behalf by:

_____ (Name of person asked to write recommendation)

Furthermore, I grant the above named person permission to release specific and personally identifiable information about me from my educational record in order that he/she may fulfill my request to write a letter of recommendation. He/she may release to the party or parties named below:

- () any such information he/she may release, or
- () only the information listed on the reverse side.

The above named person may also release the information verbally to the party or parties listed below.

This waiver is not operative and becomes null and void if at any time said letter or letters of reference or confidential recommendations are used for any purpose other than these which are specifically intended. My specific intention is:

- () respecting admission to an educational agency or institution
- () other (specify): _____

Such a letter of reference of confidential recommendations is to be sent to: Program Director, School of Medical Technology, for each school indicated below:

_____ Comanche County Memorial Hospital Lab; Gary Jackson, SH(ASCP)CLS; Program Director; Box 129; Lawton, OK 73502-6377; Phone: (580) 355-8699, ext 3362; Fax: (580) 585-5462

_____ Muskogee Regional Medical Center Lab; Mitchell Watrous, MA Ed, MT(ASCP); Program Director; 300 Rockefeller Drive; Muskogee, OK 74401-5081; Phone: (618) 684-2299; Fax: (918) 684-2223

_____ Saint Francis Hospital Laboratory; Theresa Foster, MPH, MT(ASCP)SH; Program Director; 6161 South Yale Avenue; Tulsa, OK 74136-1902; Phone: (918) 494-6342; Fax (918) 494-1497

_____ Valley View Regional Hospital Lab; Leah Babcock, MT(ASCP); Program Director; 430 North Monta Vista; Ada, OK 74820; Phone: (580) 421-1550; Fax: (580) 421-1525

Signature of Waiving Party (Applicant)

Date