

## RECOMMENDATION FORM

**APPLICANT:** Please clearly print your information below before giving the form to the individual submitting your recommendation.

**SHPEP ID NUMBER** \_\_\_\_\_

**NAME** \_\_\_\_\_  
LAST FIRST MIDDLE

**PHONE NUMBER** \_\_\_\_\_

**EMAIL ADDRESS** \_\_\_\_\_

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**RECOMMENDER:** Please clearly print your information. If you choose to submit a letter in addition or in substitution of this form, it must be printed on official institution letterhead and include the first page of this form to assist with matching it to the correct application.

Please email your recommendation to [SHPEPLetters@aamc.org](mailto:SHPEPLetters@aamc.org). If you are unable to access email, please mail your recommendation to the address below:

Summer Health Professions Education Program  
Association of American Medical Colleges  
655 K Street NW, Suite 100  
Washington, DC 20001-2399

**REFERENCE PROVIDED BY:**

**NAME** \_\_\_\_\_

**COLLEGE/UNIVERSITY/COMPANY** \_\_\_\_\_

**TITLE/POSITION** \_\_\_\_\_

**DEPARTMENT** \_\_\_\_\_

**EMAIL ADDRESS** \_\_\_\_\_

**THE DEADLINE TO EMAIL A RECOMMENDATION IS FEBRUARY 15, 2019.  
MAILED RECOMMENDATIONS MUST BE POSTMARKED BY FEBRUARY 15, 2019.**

**PLEASE RATE THE APPLICANT ON THEIR ATTRIBUTES AND SKILLS BELOW:**

	Outstanding	Good	Fair	Poor	Unable to Judge
Intellectual ability					
Integrity					
Work habits					
General motivation					
Leadership					
Imagination/creativity					
Initiative					
Ability to work with others					
Maturity					
Writing skills					
Verbal communication					

In what capacity do you know the applicant?

Do you have any concerns about this student's ability to participate in an intensive six-week residential program designed to increase his/her preparedness for application and matriculation to a health professions school?

I have no concerns.

I have concerns about this student.

Please share anything you think is important for us to know about this student. Use additional paper, if necessary.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_