CONFIDENTIAL RECOMMENDATION REPORT

ADVANCED CLINICAL TRAINING OR PRECEPTORSHIP APPLICATION

Name of applicant: _____
(Last) (First)

Name of program: _____

How long have you known this applicant: _____

What is your relationship to this applicant: _____

The applicant has waived the right to access this evaluation.

Please evaluate the applicant in the following categories:

ATTRIBUTE	EXCEEDS EXPECTATION	MEETS EXPECTATION	DOES NOT MEET EXPECTATION	COMMENTS: *(REQUIRED FOR EXCEEDS OR DOES NOT MEET EXPECTATION RATING)*
Critical Thinking				
Didactic Knowledge				
Clinical Skills				
Interpersonal Skills and Communication				
Integrity and Ethics				
Maturity				
Organizational Skills				
Professional Demeanor				
Reaction to Criticism				
Self-Awareness				
Motivation				

Additional remarks:

OVERALL, I WOULD:

RECOMMEND WITHOUT RESERVATION	HIGHLY RECOMMEND	RECOMMEND	NOT RECOMMEND

Evaluator contact information:

Name of evaluator: _____Date of form completion: _____
Occupation: _____

Address:_____ email address: _____
(name of institution/practice)
_____ Telephone number: _____
_____

Evaluator signature: _____

Please complete this form and mail directly to UCLA School of Dentistry, Postgraduate Programs Officer, 10833 Le Conte Ave., CHS 33-039, Los Angeles, CA 90095-1668