APPLICANT EVALUATION FORM

Johns Hopkins Hospital

Postgraduate Physician Assistant Surgical Residency

Applicant: Please fill in your name, mailing address and sign Waiver. Provide a standard business size envelope to Evaluator or have them email this form directly to pasurgres@jhmi.edu.

Evaluator: Please fill out this form or provide a letter of recommendation regarding the applicant. If writing a letter instead, be sure to include comments on all of the categories listed on this evaluation form. The evaluation form or letter can be mailed in the envelope provided by the applicant or emailed by you directly to pasurgres@jhmi.edu. Because of federal legislation giving students access to educational records, the PA Surgical Residency Program cannot guarantee the confidentiality of your statement unless the applicant has signed the waiver printed at the right.

APPLICANTS WAIVER OF RIGHT OF ACCESS TO CONFIDENTIAL STATEMENT: I hereby freely and voluntarily waive my right of access to to any information contained On this recommendation form and agree that the student shall remain confidential.

_____
(signature)

_____
(date)

Applicant's Name :_____
Last First Middle

Applicant's Mailing Address: _____
Street City State Zip

To the person recommending the applicant: The Johns Hopkins Hospital Postgraduate PA Surgical Residency Program greatly appreciates your completion of this form. If you are returning this form directly to the applicant, please seal your evaluation in the envelope provided by the applicant, and write your name across the back seal. The form can also be emailed directly to pasurgres@jhmi.edu. Thank you!

For how long, and in what relationship, have you known the applicant? _____

_____

Please comment on the strength and weaknesses of the candidate according to your knowledge of him/her, in the following areas:

Intellectual Ability: _____

_____

_____

Motivation/Perseverance:_____

_____

_____

Ability To Work With Others: _____

_____

_____

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Maturity/Emotional Stability: _____

_____

_____

Personal Integrity:

_____

_____

Professionalism: _____

_____

_____

Flexibility/Ability to Adapt:

_____

_____

_____

Have you observed the applicant's interactions with patients? ☐ **Yes** ☐ **No**

If yes, please comment on the applicant's interaction style: _____

_____

_____

Additional comments:_____

_____

_____

_____

May we contact you by telephone for additional information? _____

Recommendation concerning admission (check one):

☐ The applicant has my highest recommendation.

☐ I recommend the applicant with confidence.

☐ I recommend the applicant with some reservations.

☐ I do not recommend the applicant.

Signature _____ Date _____

Name Printed or Typed _____ Title/Dept._____

Institution _____

Address _____

Telephone No (____) _____ E-Mail _____

Upon completion, please seal this form in the envelope provided by the applicant and place your signature across the back seal and mail directly to residency program or give back to applicant. The form can also be emailed by the evaluator directly to the residency email address provided on this form.