



Applicant Name: \_\_\_\_\_  
Contact Number: \_\_\_\_\_

**SCHOOL OF ALLIED HEALTH**  
**Dental Assisting Program**  
**Allied Health Science Bldg. Suite 160**  
**3211 Providence Drive**  
**Anchorage, Alaska 99508-8371**

**Voice: 907-786-6929**  
**Fax: 907-786-6938**

**GENERAL RECOMMENDATION CONCERNING**

Name of Applicant: \_\_\_\_\_  
Last First MI Previous Name(s)

**TO THE CANDIDATE:**

Please check one of the following options before you send or give this form to the person recommending you. This form **will NOT** be placed in your application file if you fail to designate the **option of your choice or fail to sign below**

**PLEASE CHECK ONLY ONE OPTION**

- NON-CONFIDENTIAL RECOMMENDATION:** The above named person elects to keep this recommendation non-confidential and the recommendation may be shown to the applicant at his or her request.
- CONFIDENTIAL RECOMMENDATION:** I elect to keep this recommendation confidential and I waive all my rights of access to this recommendation, whether visual, oral or written, as provided in the Family Educational Rights and Privacy Act of 1974 and its amendments. I understand that this recommendation will not be available for my inspection now or in the future.

\_\_\_\_\_  
Candidate's Signature and Date  
Must be signed and dated to be valid



Applicant Name: \_\_\_\_\_  
Contact Number: \_\_\_\_\_

1. How long have you known the applicant and in what capacity?
  
2. When were you last associated with the applicant?
  
3. What do you consider to be the main qualities of strength and weakness of this applicant? If possible, give examples.
  
4. Do you place full confidence in the applicant's integrity?  Yes  No  
If not, please explain.
  
5. Does the applicant like to work with people?  Yes  No  
What experiences has this applicant had which supports your answer?

6. Check the box that best describes each quality for this applicant.

	Excellent	Good	Average	Fair	Poor
Interpersonal Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Initiative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teamwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reliability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooperation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disposition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Occupation/Position/Title

\_\_\_\_\_  
Printed Address

\_\_\_\_\_  
Telephone Number

Please indicate your endorsement of this applicant by checking one of the following:

- Highly Recommend       Recommend       Uncertain       Do Not Recommend

***Please write any additional comments on a separate sheet of paper.***

This letter of reference will be placed in the applicant's file to be used by the selection committee and faculty advisors.

Please return this form to: University of Alaska Anchorage  
Dental Programs AHS 160  
3211 Providence Drive  
Anchorage, AK 99508-8371