CONFIDENTIAL STATEMENT OF RECOMMENDATION FOR RADIOGRAPHY CERTIFICATE PROGRAM

Complete and return to: School of Radiography, Piedmont Augusta, 1350 Walton Way, Augusta, Georgia 30901-2612.

TO THE CANDIDATE: By signing below you are waiving your right to read the recommendation.

CONFIDENTIAL: Not Subject to My Review
I request that my reference complete this recommendation form. Your candid evaluation of me and information from school records is being sought and will be held in strict confidence both from me and the public by the Stephen W. Brown, School of Radiography.

Applicant's Name _____ Date _____

APPLICANT: Complete the following section

Applicant Name _____ Address _____

Reference Name _____ Address _____

The Family Education Rights & Privacy Act, as amended, allows an individual to waive the right to view confidential recommendations. The individual named above has waived that right and **this recommendation will be confidential.**

REFERENCE: Complete the following section. **(please answer all questions)**

1) In what capacity have you been acquainted with the applicant and for what length of time?

2) Please check the following as it applies to the applicant.

	Low-third	Low-third	High-third	N/A
a) Motivation Shows an interest in learning: has a desire to excel	☐	☐	☐	☐
b) Perseverance Persistent and consistent in efforts to achieve	☐	☐	☐	☐
c) Ability to get along with others Works well with others: courteous and cooperative	☐	☐	☐	☐
d) Attitude toward criticism Leans from mistakes: receptive to suggestions	☐	☐	☐	☐
e) Emotional stability Exercise self-control: maintains composure in difficult situation; adjusts to change	☐	☐	☐	☐
e) Maturity Accepts responsibility: dependable, respectful	☐	☐	☐	☐

Do you recommend the applicant for entry into the profession of radiologic technology?

Not recommended ☐
Recommended with reservations ☐
Recommended with confidence ☐
Recommended enthusiastically ☐

Comments:

Reference Signature _____ Date _____

Position/Title _____ Phone Number (for further clarification if necessary) _____

E-mail your completed for to: nancy.edwards@piedmont.org

Please
place
stamp
here.

PIEDMONT AUGUSTA
SCHOOL OF RADIOGRAPHY
1350 WALTON WAY
AUGUSTA GA 30901-2612