

# REFERENCE FORM FOR APPLICANTS TO ALLIED HEALTH PROGRAMS



Emory University  
 Medical Imaging Program  
 P.O. Box 25901  
 Atlanta, GA 30322

**TO THE APPLICANT:** Complete this part of the form and then send to the persons who have agreed to complete it for you. Include a stamped envelope addressed to the above address or have the person providing the reference place the form in a sealed envelope for inclusion with other official application documents.

**FULL LEGAL NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

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

**PROGRAM AND SEMESTER OF ADMISSION** \_\_\_\_\_

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**NAME OF INDIVIDUAL PROVIDING REFERENCE** \_\_\_\_\_

**In terms of the qualities listed below, please give us your appraisal of the applicant.**

**How long have you known the applicant?** \_\_\_\_\_

**In what capacity?** \_\_\_\_\_

	Exceptional	Outstanding	Above Average	Average	Below Average	Unable to Assess
Intellectual Ability						
Integrity						
Maturity						
Motivation/Initiative						
Ability to work with others						
Oral Communication						
Written Communication						
Leadership/Managerial Potential						
Analytical Ability						
Judgment						
Overall Rating						

Interpersonal Attributes (relationship with peers and authority figures)

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Communication Skills (writing and speaking, poise, clarity or presentation of ideas)

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# EMORY UNIVERSITY MEDICAL IMAGING PROGRAM



Intellectual Ability (conceptualization, ability to transfer and utilize knowledge in problem solving)

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Maturity and judgment (decision making, setting priorities, dependability)

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Leadership ability or potential (organization, time management)

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Please use this space to provide any qualifying or supporting recommendations that you wish to make.

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**Note:** Thank you for providing this information. Emory is committed to a policy of nondiscrimination on the basis of race, color, creed, sex, national or ethnic origin, handicap, age or veteran's status.