Admissions Reference Form
St. Vincent's Medical Center, Jacksonville, Florida 32204
School of Radiologic Technology

Attention Applicant:

Complete Part I (by printing of typing) and Part II, then give the form to your reference for completion of Part III. References should be teachers, employers, clergy, coaches or others in positions of authority with whom you have worked or learned. Have him/her return to you in sealed envelope with his/her signature over the closure edge. Return with your application package to the Program Director.

Please print except for signatures.

PART I

Applicant Name: _____

Applicant Address: _____

Reference Name: _____

Reference Position/Title & Relationship to Applicant: _____

PART II
TO THE APPLICANT:

You must indicate whether or not you desire to waive your right of access to this document. If you decide not to waive your right, this fact will not affect your chances of acceptance in any manner. If you wish to waive your right of access, read and sign the statement below. If you desire not to waive your access right, do NOT sign the statement.

I hereby waive my right to see this Reference Form:

_____
Applicant's Signature

PART III:
TO THE REFERENCE:

The above named applicant has applied to the School of Radiologic Technology program at St. Vincent's and has given your name as a reference. The applicant indicated above whether he/she has or has not waived access to this form. If access is waived, your reference will be kept confidential to the maximum extent allowed by State and Federal Law.

1. Please outline briefly in the space below in what capacity and for how long you have known the applicant:

2. Do you have any reason to doubt this applicant's integrity or honesty? If yes, please explain. (continue on back if necessary)

☐ Yes ☐ No

3. Do you think the applicant is prepared and has demonstrated characteristics you think would be important to undertake a rigorous 24 month program of study and clinical experience caring for patients?

☐ Unknown ☐ Do not recommend ☐ Recommend ☐ Strongly Recommend

(continue on back)

4. Please indicate with a check mark in appropriate column your candid appraisal of the candidate for each of the following.

CHARACTERISTICS	Not Observed	Poor	Fair	Good	Excellent
a. General Academic Ability					
b. Industry - Perseverance					
c. Conscientiousness					
d. Quality of Oral Expression					
e. Quality of Written Expression					
f. Inquisitiveness					
g. Imagination					
h. Motivation for Chosen Profession					
i. Ability to Work With Others					
j. Attitude Toward Others					
k. Consideration/Compassion					
l. Maturity					

5. Please comment on any outstanding traits or characteristics of the applicant.

6. Please indicate your overall recommendation for this applicant for a patient care profession.

☐ Not recommended ☐ Recommended ☐ Strongly recommended

Please sign this form below, seal in an envelope and sign your name across the sealed edge. Return sealed envelope to applicant for inclusion with their completed application package which is due to the program before May 15. If you have questions regarding this program or reference form, please contact the Program Director at St. Vincent's, by calling 904-308-8552.

_____ _____

Signature of Respondent Telephone # or e-mail address where you can be reached for verification

_____ _____

Print Name Date Completed