

**Southern Illinois University Edwardsville**  
**SCHOOL OF PHARMACY**  
 Evaluation Form / Doctor of Pharmacy Program

**Part 1. To be completed by the applicant.**

Complete the **Release of Access** section and then sign and date before giving to your evaluator. **Forms may be completed by instructors, employers, or health care professionals (e.g. pharmacists, nurses, dentists, physicians). Forms completed by SIUE School of Pharmacy faculty or relatives are not acceptable.** IMPORTANT: Provide the evaluator with a stamped envelope addressed to you. Upon completion of the recommendation form, your evaluator should return the evaluation to you in a sealed envelope. Please instruct the evaluator to sign the envelope across the flap prior to mailing. **All elements of your application must be received by December 1<sup>st</sup>, 2009.**

**You are responsible for sending two evaluations to: School of Pharmacy Admissions, c/o SIUE Service Center, Box 1080, Edwardsville, IL 62026-1080. Letters of evaluation not submitted on this form will not be accepted.**

Name (Last, First, MI): \_\_\_\_\_

Year for which you are applying: \_\_\_\_\_ Social Security No: \_\_\_\_\_

**Release of Access to this Letter of Evaluation:**

You must complete and sign the following statements before submitting this form to the evaluator. This request is in compliance with Federal Law P.L. 93-80 (Family Educational Rights and Privacy Act of 1974) as amended.

\_\_\_\_ I waive my right of access to this letter of evaluation.

\_\_\_\_ I do **not** waive my right of access to this letter of evaluation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Part 2. To be completed by the evaluator.**

The person named above is applying for admission to the Southern Illinois University Edwardsville School of Pharmacy. You have been selected by the applicant to provide an evaluation of his/her qualifications for a career in pharmacy. The information that you provide will be used as part of the applicant's admissions file and will be considered by the Admissions Committee of the School of Pharmacy.

Please complete and enclose this form in the envelope provided to you by the applicant, sign your name across the flap and return it to the applicant. **Evaluations not on this form will not be accepted. However, you may attach additional pages if necessary.**

Name of Evaluator: \_\_\_\_\_ Phone: \_\_\_\_\_

Nature of acquaintance with applicant (e.g. supervisor, teacher): \_\_\_\_\_

Length of acquaintance: \_\_\_\_\_ Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Please use the five point rating scale (with 5 being the highest) to indicate the frequency with which the candidate you are evaluating demonstrates the characteristic listed. N/I (no information) indicates that you have no basis for judging the candidate with regard to this characteristic. Thank you for your assistance.

	1	2	3	4	5	N/I
Intellectual Ability - Demonstrates the ability to learn and reason and to acquire and apply knowledge.						
	1	2	3	4	5	N/I

