



Riverside Orthopedic Physical Therapy Residency Program

RECOMMENDATION FORM

Name of Applicant:

Individual(s) providing recommendation(s):

Name/Credentials:

Current Position:

Mailing Address:

Phone Number:

Email Address:

Are you willing to discuss this Applicant's qualification over the phone with a member of the selection committee? (Circle the appropriate response). Yes No

Relation of Individual providing recommendation to Applicant (Circle the appropriate response):

Clinical Supervisor

Employer

Academic Instructor

Professional Colleague

Other (please specify):

Number of years known Applicant:

Less than 2

2 to 5

Greater than 5

Compared to other Applicants that you would recommend to this residency program, the Applicant would rank in the:

Top 1%

Top 5%

Top 10%

Top 25%

Top 50%

What is the most valuable quality or characteristic that the Applicant possesses?

Provide a brief example or description illustrating your observation of the Applicant's use of that quality or characteristic.

Please feel free to attach other information pertinent to the application's recommendation.

(Thank you for taking the time to recommend this Applicant to our residency program)

Riverside Orthopedic Physical Therapy Residency Program – continued