

PERSONAL EVALUATION OF APPLICANT UNIVERSITY OF LOUISVILLE SCHOOL OF DENTISTRY

To the applicant: Before you give this form to your evaluator, indicate whether you waive your right of access to this evaluation.

Applicant Name (print or type) Social Security Number

The Family Rights and Privacy Act of 1974 gives you a right of access to an evaluation written about you, but also says that you may waive that right. Indicate whether or not you waive your right to access this evaluation by marking the appropriate statement, signing and dating below.

I waive this right I do not waive this right

Applicant Signature Date

EVALUATOR (print or type) **POSITION OR DEPARTMENT**

1. In what capacity have you been associated with the applicant? _____
- _____
2. How long have you known the applicant? _____
3. How well have you known the applicant? very well fairly well slightly

	<u>Outstanding</u> Top 5%	<u>Excellent</u> Next 10%	<u>Good</u> Next 25%	<u>Average</u> Next 40%	<u>Below</u> <u>Average</u> Bottom 20%	<u>No Basis</u> <u>for</u> <u>Judgment</u>
View of profession of dentistry						
Maturity, Self-discipline						
Motivation						
Reasoning ability (analysis, insight, judgment, common-sense, problem-solving)						
Independent thinking (originality, creativity)						
Communication skills:						
--Oral						
--Written						
Manual dexterity						

In the space below, indicate your observations about this person's character and academic potential to succeed in the D.M.D. curriculum.

How do you recommend this individual as a candidate for admission to the University of Louisville School of Dentistry?

_____ outstanding _____ excellent _____ good _____ average
_____ below average _____ cannot recommend

Evaluator's Signature

Date

College/University

Return Address
(print or type so acknowledgment may be sent)

Please return this form to: **University of Louisville School of Dentistry**
Office of Student Affairs, Room 231
Louisville, KY 40202