OKLAHOMA SCHOOL OF MEDICAL TECHNOLOGY/CLINICAL LABORATORY SCIENCE

STUDENT ACADEMIC EVALUATION FORM

NAME OF STUDENT (Please print name in full): _____

I. SCHOLASTIC ABILITY

A. Where would you rank this applicant with those currently in your department/class? Please indicate ranking criteria: class ( ) department ( ) other ( )

LOWER 1/3 ( ) MID 1/3 ( ) UPPER 1/3 ( )

B. In your opinion, is the applicant's scholastic record an accurate index?

YES ( ) NO ( ) DON'T KNOW ( )

ADDITIONAL COMMENTS:

II. PERSONAL APPRAISAL

A. How long have you known this applicant? ( ) less than 1 year ( ) 2-3 years ( ) 3 or more years

In what capacity? ( ) Instructor - List course(s)._____ ( ) Advisor

B. Rate the applicant on the following qualifications, in comparison to other students in classes.
(5 = Outstanding; 3 = Average; 1 = Poor)

5	4	3	2	1	Not Observed	
						Psychomotor
_____	_____	_____	_____	_____	_____	Manual dexterity
_____	_____	_____	_____	_____	_____	Laboratory skills
_____	_____	_____	_____	_____	_____	Safe practices
_____	_____	_____	_____	_____	_____	Accuracy of results
						Cognitive
_____	_____	_____	_____	_____	_____	Academically competent
_____	_____	_____	_____	_____	_____	Written expression
_____	_____	_____	_____	_____	_____	Oral expression
_____	_____	_____	_____	_____	_____	Critical thinker/problem solver
						Affective
_____	_____	_____	_____	_____	_____	Motivation
_____	_____	_____	_____	_____	_____	Cooperation with other
_____	_____	_____	_____	_____	_____	Adaptable/flexible to change
_____	_____	_____	_____	_____	_____	Follows instructions
_____	_____	_____	_____	_____	_____	Emotional stability
_____	_____	_____	_____	_____	_____	Leadership skills

C. Overall recommendation:

_____ Highly Recommended _____ Recommended with Reservations

_____ Recommended _____ Not Recommended

NAME: _____ TITLE: _____

SIGNATURE: _____ DATE: _____

INSTITUTION: _____

PERMISSION TO RELEASE PERSONALLY IDENTIFIABLE AND/OR WAIVER OF RIGHT TO INSPECT OR REVIEW CONFIDENTIAL LETTER OF RECOMMENDATION (FAMILY EDUCATION RIGHTS AND PRIVACY ACT OF 1974, AS AMENDED)

I, _____, ( ) do ( ) do not hereby waive and renounce all right of access, including those established by the Family Education Rights and Privacy Act of 1974, to any letter or letters of reference or confidential letters of recommendation to be hereafter written in my behalf by:

_____ (Name of person asked to write recommendation)

Furthermore, I grant the above named person permission to release specific and personally identifiable information about me from my educational record in order that he/she may fulfill my request to write a letter of recommendation. He/she may release to the party or parties named below:

( ) any such information he/she may release, or
( ) only the information listed on the reverse side.

The above named person may also release the information verbally to the party or parties listed below.

This waiver is not operative and becomes null and void if at any time said letter or letters of reference or confidential recommendations are used for any purpose other than these which are specifically intended. My specific intention is:

( ) respecting admission to an educational agency or institution
( ) other (specify): _____

_____

Such a letter of reference of confidential recommendations is to be sent to: Program Director, School of Medical Technology, for each school indicated below:

_____ Comanche County Memorial Hospital Lab; Stacey Paryag, MPA, AHI(AMT), MLS(ASCP)^{CM}; Program Director; 3401 West Gore Boulevard, Lawton, OK 73505; Phone: (580) 355-8699, ext 4762; Fax: (580) 585-5462

_____ Saint Francis Hospital Laboratory; Theresa Foster, MPH, MT(ASCP)^{CM}SH; Program Director; 6161 South Yale Avenue; Tulsa, OK 74136-1902; Phone: (918) 494-6342; Fax (918) 494-1497

_____ Valley View Regional Hospital Lab; Leah Babcock, MSHR, MT(ASCP); Program Director; 430 North Monta Vista; Ada, OK 74820; Phone: (580) 421-1596; Fax: (580) 421-1525

_____
Signature of Waiving Party (Applicant)

_____
Date