Teacher Recommendation Form

Applicant’s Name: ______________________________________ Date: _________________

High School Name: __________________________________________

Please give this form to your teacher to send directly to us. Please sign below if you waive your right to access this recommendation letter.

Signature of applicant: __________________________________________

Dear Evaluator:

Please evaluate the above applicant in relation to other students at the same level of training.

How well do you know this applicant? (Please include length of time and your association.)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Outstanding = top 10%  Good = top 25%  Average = 50%  Poor = bottom 10%

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<tr>
<th>Rating of Characteristics</th>
<th>Outstanding</th>
<th>Good</th>
<th>Average</th>
<th>Poor</th>
<th>No opinion</th>
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Other comments or concerns (attach additional pages if needed):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Overall recommendation:  Strongly recommend ___ Recommend ___ Do not recommend ___

Name of Evaluator (Please print legibly):____________________________________________

Signature: ___________________________ Date: ___________________________

Teacher’s e-mail address _______________________________________________________

High School Name: _____________________ Phone: _____________________

Address: ___________________________________________________________________

Please mail or fax the completed form to:

Dr. Behnoosh Afghani
UC Irvine Medical Center
101 City Drive South, Bldg 26
Orange, CA 92868
Fax: 714.456.7182

Or scan and e-mail to: bafghani@uci.edu