

SAINT FRANCIS UNIVERSITY
Master of Physician Assistant Sciences

Applicant Evaluation Form

TO BE COMPLETED BY THE APPLICANT:

Applicant: Please fill in your name and social security number so that it coincides with your application form.

Applicant's Name (L,F,I): _____

Social Security #: _____

Please check and sign below:

I hereby waive ___ do not waive ___ my right to have access to this evaluation form required for admission to the Saint Francis College Physician Assistant Program.

Signed: _____ Date: _____

(If no check is made above, the Program assumes that you do not waive access.)

TO BE COMPLETED BY THE EVALUATOR:

Name of Evaluator: _____

Position and Title: _____

Address: _____

Daytime Phone: _____

Please check and sign below:

This evaluation is submitted with understanding that the applicant has ___ has not ___ waived access as indicated above.

Signature: _____ Date: _____

TO BE COMPLETED BY THE EVALUATOR:

1. In what capacity did/do you know the applicant? _____

2. How long have you known the applicant? _____

3. Please rate the applicant on the following grid relative to others that you have known in the same capacity in recent years.

	Outstanding	Excellent	Good	Fair	Poor	Cannot Evaluate
Intellectual Ability						
Communication Skills						
Maturity						
Adaptability						
Team Skills						
Dependability						
Conflict Resolution						
Patient Interaction						
Awareness of Limitations						
Reaction to criticism						
Overall Evaluation						

Please provide a letter of reference in the space below (or attached on a separate sheet of paper).

Signature: _____ Date: _____