American Society of Health-System Pharmacists
Residency Applicant Recommendation Request Form

Request for Recommendation by Applicant to Pharmacy Residency Program at: **Intermountain Healthcare**

To be completed by applicant: please type -or- print legibly

Applicant Information: _____
First Name MI Last Name

_____
Street Address or P.O. Box

_____ (_____) _____-_____
City State Zip Code Telephone Number

I waive the right to review this recommendation: _____
Signature of Residency Applicant

To the recommender: Please complete this form by **January 5** and return to:

Richard H. Ensign II, PharmD, BCPS
Pharmacy Services Manager & Residency Program Director
Intermountain Healthcare
36 South State Street, Suite 1700
Salt Lake City, Utah 84111
Phone: (801) 442-3232
Fax: (801) 442-3133
E-mail: richard.ensign@imail.org (preferred method)

Applicants to the residency program specified above are required to have recommendations submitted by persons who are in a position to evaluate their qualifications for residency training. The recommender is asked to make a frank appraisal of the applicant's character, personality, abilities and suitability for a pharmacy residency. Recipients of this information are asked to keep it confidential.

For the recommender to complete: please type -or- print legibly

I have known the applicant for approximately _____ ☐ months ☐ years

My relationship to the applicant was (or is) in the following capacity:
☐ faculty advisor ☐ employer ☐ clerkship preceptor ☐ supervisor
☐ other faculty relationship ☐ other (please specify) _____

I know him/her: ☐ very well ☐ fairly well ☐ only casually

Does the applicant possess any special assets which should be noted?

Does the applicant demonstrate any weaknesses that you feel would hinder his/her ability to perform effectively in a residency program?

Other Comments (use additional pages if necessary):

Relative to persons of similar background, training and professional interests, how would you rate this applicant for each of the following characteristics? Please place an X under the rating column which best describes the applicant.

CHARACTERISTICS EVALUATED	UPPER 10%	UPPER 25%	UPPER 50%	LOWER 50%	NO BASIS FOR JUDGMENT
Academic ability					
Quality of work					
Written communication skills					
Oral communication skills					
Leadership skills					
Industriousness and perseverance					
Initiative and motivation					
Assertiveness					
Cooperativeness					
Ability to organize and manage time					
Ability to work with supervisors					
Ability to work with peers					
Ability to work with patients					
Dependability					
Resourcefulness and originality					
Willingness to accept constructive criticism					
Personal appearance and professional demeanor					
Commitment to professional practice					
Emotional stability and maturity					
Enthusiasm					
Integrity					

Recommendation concerning admission (check one):

☐ I highly recommend this applicant ☐ I recommend this applicant, but with some reservation

☐ I recommend this applicant ☐ I am not able to recommend this applicant

_____ _____
Signature of Recommender Date

_____ _____
Name Title

_____ _____
Affiliation e-mail

_____
Street Address or P.O. Box

_____
City State Zip

(_____) _____-_____
Telephone Number