RECOMMENDATION
DIVISION OF GRADUATE MEDICAL SCIENCES
BOSTON UNIVERSITY SCHOOL OF MEDICINE

TO THE APPLICANT:

This recommendation form is for members of the faculty at Boston University, faculty members at other universities at other universities where you have studied, and outside employers. **Recommendations should be written on your recommenders' official stationery and attached to this form. Please print your name, Social Security Number, and year of expected professional school entrance on the top line on the back of this form.**

Under the Family Educational Rights and Privacy Act of 1974, Boston University students are entitled to access to letters of evaluation contained in their permanent educational records at Boston University. However, a student may waive this right of access to letters of evaluation. If this right of access is waived, letters of evaluation will be considered confidential and will not be available to the student. If you wish to waive your right of access to this letter of evaluation, please indicate that wish by signing your name on the line below the following statement:

I WAIVE MY RIGHT OF ACCESS to the contents of my folder and ask that Boston University hold it in confidence so that it is available only to the University and to the professional schools to which I apply.

Signed____ Date_____________________________

If you choose not to waive your right of access, please indicate that wish by signing your name on the line below the following statement:

I DO NOT WAIVE MY RIGHT OF ACCESS To the contents of my folder.

Signed____ Date_____________________________

TO THE EVALUATOR:

Please assess the above named student's intellect, personality, and character—particularly those qualities which bear on his or her promise as a physician, dentist, or health professional. It would be helpful to note the state of the student's preparation for graduate study and ability in writing and/or independent work. The listing of any special honors, awards, and unusual interests, abilities, and accomplishments that are of importance is also helpful. Please indicate how long you have known the student and list the courses in which you have taught him/her. **Your statements will be sent directly to the professional schools.**

Please type, using the general salutation, "Dear Admissions Committee", and return directly to: Susan Wilcox, Director, Division of Graduate Medical Sciences, Room L317, 715 Albany Street, Boston, MA 02118.

NOTE:

Unless this applicant has signed the above statement of waiver, Boston University will **NOT** consider this letter of evaluation confidential.

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BOSTON UNIVERSITY SCHOOL OF MEDICINE

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STUDENT'S NAME (PLEASE PRINT)	**BU ID #**	**YEAR OF EXPECTED PROFESSIONAL SCHOOL ENTRANCE**

Recommender: Please write your recommendation on your letterhead and return this form with your letter to:

Susan Wilcox
Director
Room L-317
Division of Graduate Medical Sciences
Boston University School of Medicine
715 Albany Street
Boston, MA 02118

Thank you.

SIGNED______________________________ **DATE**______________________

NAME____________________ **TITLE**____________ **DEPARTMENT**__________

PLEASE PRINT YOUR NAME AND TITLE