

Saint Joseph Regional Medical Center Pharmacy Practice Residency Program Letter of Recommendation

Applicant Name: _____
 (Print or Type: First Name, Middle Initial, Last Name)

Applying for the Pharmacy Practice Residency Program in an: **Ambulatory Care Setting** **Acute (hospital) Care Setting**

I waive the right to review this recommendation _____
 (Signature of Applicant)

Reference Name: _____

Title: _____

Address: _____

Phone: _____ E-Mail: _____

I have known the applicant for approximately _____ month/years. My relationship to the applicant was that of _____.

I know him/her _____ very well. _____ fairly well. _____ only casually.

In addition to ranking the resident below, in a separate letter please comment on the character and ability of the resident to function effectively in a pharmacy practice residency. Please address additional information that may be helpful to the selection process including the answers to the following questions:

1. What special strengths do you feel the applicant possesses that should be noted?
2. What weaknesses do you feel the applicant possesses that should be noted?

Please rank the applicant on the following traits in comparison with others at the same level of experience and training:

	Unable to Rank	Unsatisfactory	Satisfactory	Exceptional
Ability to communicate orally effectively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to communicate in writing effectively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to organize and prioritize workload	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to multitask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work and cooperate with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to provide leadership	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to provide direct patient care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to teach others pharmacotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to accept constructive criticism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distribution/Medication control skill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Skill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motivation/Enthusiasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional stability/Maturity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assertiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integrity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Recommendation for acceptance into the residency program:

- The applicant has my highest recommendation
- I recommend the applicant with confidence
- I recommend the applicant with some reservation
- I am unable to recommend the applicant

Signature: _____

Date: _____

Please return this form, with the letter of recommendation, no later than January 17th to:

Ed Sheridan, PharmD
 Pharmacy Practice Residency Program Director
 837 East Cedar Street, Suite 125
 South Bend, Indiana 46617
 Phone: 574-237-7637
 E-mail: SheridanE@sjrmc.com