UNIVERSITY OF MICHIGAN-FLINT
NURSE ANESTHESIA PROGRAM

Doctor of Nurse Anesthesia Practice
Office of Graduate Programs
University of Michigan-Flint
251 Thompson Library
Flint, Michigan 48502-1950
FlintGradOffice@umich.edu

RECOMMENDATION REQUEST

_____ _____
Name of Recipient Date

_____
Name of Applicant

The above-named individual has applied for admission to the University of Michigan-Flint Doctor of Nurse Anesthesia Practice (DNAP) program for registered nurses. The Anesthesia Program Admissions Committee would appreciate your assistance in determining the applicant's potential for success both as a student and as a future nurse anesthetist. Please return the completed appraisal to the address above, as the application is considered incomplete until the University receives this form. Your personal letter is a welcome addition. All appraisals are held in confidence.

Thank you,
Gena Welch, DrAP, CRNA
Director, University of Michigan-Flint Nurse Anesthesia Program

Please note you cannot fill this form out online; please download and save, fill out and send upon completion to FlintGradOffice@umich.edu.

APPLICANT:
I approve this request for information and waive my right to inspect the recipient's completed remission.

_____ _____
Signature of Applicant Date

Relationship to applicant: Immediate Supervisor School of Nursing Faculty Other (Explain below)

_____

How long has the recipient known the applicant?

_____

Please continue on page 2

Please check the appropriate rating for each of the following traits.	Outstanding Top 5%	Good Top 25%	Average Top 50%	Below Average	Insufficient Knowledge to Rate
Reliability					
Honesty					
Reaction under stress					
Gets along with others					
Leadership					
Acceptance of criticism					
Problem solving/critical thinking					
Clinical skills					
Communication skills					
Initiative/work ethic					

1. Have you ever known the applicant to abuse drugs or alcohol? __Yes __No
   _____
2. What are the applicant's strengths?

   _____
3. What are the applicant's weaknesses?

   _____
4. What is your overall recommendation regarding the applicant?

   _____
5. Would you be comfortable with this individual taking care of your critically ill patient?
   __Yes __No

   _____

Recipient Information:

Signature_____ Date_____

Name (printed)_____ Title_____

Organization_____Dept _____

City _____ State _____ Zip _____

Phone (daytime) _____ Email _____