RMH
SCHOOL OF RADIOLOGIC TECHNOLOGY

ROCKINGHAM MEMORIAL HOSPITAL
SCHOOL OF RADIOLOGIC TECHNOLOGY
Reference Form

Name of student applying for admission consideration:_____

The above named student has listed you as a reference on an application for admission to the RMH School of Radiologic Technology. We would appreciate your opinion regarding this individual on any of the areas listed below.

NOTE: Federal regulations require that the applicant may have access to this information.

Please Check One: →	Excellent	Above Average	Average	Below Average	Poor	N/A
SCHOLARSHIP: Mastery of academic and professional subjects.						
PERSONAL APPEARANCE: Dress, cleanliness and overall appearance.						
CO-OPERATIVENESS: Ability to work under direction.						
RESPONSIBILITY: Ability to accept assignments and follow through.						
EMOTIONAL STABILITY: Ability to react under stress in a mature and dependable manner.						
COMMUNICATION: Ability to express self.						
INTEGRITY: Adherence to honesty in dealing with others.						
PROFESSIONAL/JOB SKILLS: Ability to learn and perform tasks related to occupation.						
DEPENDABILITY: Ability to meet deadlines, attendance requirements, etc.						
PROFESSIONAL POTENTIAL: In you opinion, potential for success as a Health Care Professional with direct patient contact.						

Please complete the personal information area below to provide information which would allow program officials to contact you in the event further inquiry into this applicant's background is required.

Name:_____ Job Title:_____
Last First Middle

Occupation:_____ Address:_____
Street City State Zip Code

Telephone: Work (____) _____ Home (____) _____ Email:_____

✓ How long have you known this applicant? _____ years _____ months

✓ What is your relationship to the applicant:

_____ Employer _____ Friend
_____ Instructor _____ Relative
_____ Adviser _____ Neighbor
_____ Co-worker _____ Other:-----Please Specify_____

ANY ADDITIONAL COMMENTS YOU MAY WISH TO PROVIDE:

CERTIFICATION

The evaluation form was completed by me personally and it is my understanding that the information provided will be solely used by the Admissions Committee of Rockingham Memorial Hospital School of Radiologic Technology.

SIGNATURE:_____ DATE:_____

THANK YOU FOR YOUR ASSISTANCE IN THE EVALUATION OF THIS APPLICANT.Please return this form to: Rockingham Memorial Hospital - School of Radiologic Technology: 2010 Health Campus Drive, Harrisonburg, VA 22801. Phone (540) 433-4476

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