St. Joseph School of Nursing

200 High Service Avenue, North Providence, Rhode Island 02904

Evaluation of Applicant's Performance and Potential

Attention Applicants: References from relatives and/or friends are NOT acceptable

Applicant Name: _____

In what capacity are you acquainted with the applicant?

_____

Length of time? _____

Please rate the applicant in the following areas:

	Excellent	Good	Average	Below Average *	No Basis for Judgement
1. Ability to Work with People					
2. Ability to Handle Stress					
3. Concern for Others					
4. Leadership					
5. Motivation					
6. Intellectual Ability					
7. Personal Initiative					
8. Responsibility / Acountability					
9. Communication Skill					
10. Attendance Record					

* If rated below average, please comment

Indicate any significant limitations for success in nursing:

_____

_____

_____

_____

Indicate any special abilities for success in nursing:

_____

_____

_____

_____

Please indicate whether or not you would endorse the applicant as a suitable candidate for nursing:

Endorse with Enthusiasm _____ Endorse _____ Do not Endorse _____

Please Explain: _____

_____

_____

_____

Signature: _____ Date: _____

Position / Title: _____

Address: _____

Telephone: _____

If the applicant's signature appears at the end of the paragraph identified as "waiver", you can be assured that your evaluation will not be reviewed by the applicant. If the applicant has not signed the waiver and enrolls at this school, then the applicant will have the right to review your evaluation.

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Evaluation of Applicant's Performance and Potential Waiver Form

Applicants to the above-named institution are selected in accordance with non-discriminatory practices.

The below named applicant is a candidate for admission to this School of Nursing. We would appreciate your evaluation of the applicant's performance and evaluation. Your comments will be used by the faculty members of this School of Nursing to help them arrive at a better understanding of the applicant. Your cooperation in completing and promptly returning this form will assist both the applicant and the School of Nursing.

Name of Applicant: _____

Last First Middle

Address: _____

Number and Street

_____

City / State / Zip

Pursuant to recent federal law, a student admitted to this School of Nursing is entitled to inspect this evaluation in his or her file, unless the student has signed a vaiver of this right of access. However, the School does not require a waiver as a conditio for admission to, receipt of financial aid form, or receipt of any other services or benefits from the School. Applicants submitting names of individuals for letters of recommendation, therefore, are free to determine whether or not they wish to waive their potential right to examine such evaluations.

WAIVER

The Family Educational Rights and Privacy Act permits us to request, but not require, that you waive your right to inspect this evaluation. The right, which we request that you waive, would arise if you were an enrolled student at this school and if the evaluation were maintained after your enrollment. In considering whether you will waive, please be advised that the information contained on this form will be used to evaluate you as an applicant for admission to this School of Nursing. If you elect to waive your rights of access to and review of this information, please sign your name.

_____ _____

Date Applicant's Signature

PLEASE RETURN THIS FORM DIRECTLY TO THE DIRECTOR, SCHOOL OF NURSING

School of Nursing; **St. Joseph School of Nursing**

Address: **200 High Service Avenue**

North Providence, RI 02904