Ozarks Technical Community College
Practical Nursing Reference Form

Work-Academic-Potential to Function in Healthcare

Fall Deadline – DUE BY APRIL 1   Spring Deadline – DUE BY OCTOBER 1

Applicant's Name:____ Date:_____________________

Applicant hereby authorizes individual/business/firm/institution to whom this form has been addressed to issue any information regarding their service, character, personality and competencies, and do hereby unconditionally release named individual/business/firm/institution from all liability for any damage whatsoever which might result from furnishing this information.

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Your Response Will Be Kept Confidential

The person named above has applied to the Practical Nursing Program. Your assessment of the applicant's characteristics will enable the Practical Nursing Program to evaluate whether this applicant meets its standards. Please respond to all questions to the best of your ability. **This reference needs to be completed by a professional contact and not a family member.**

1. Reference's Name_________________________________ Profession/Occupation___________________________

   Home or Business Address____

   PositionTitle____Telephone_________________________________

   (Optional) E-mail___________________________ How do you know this applicant?_________________________

2. Please rate the applicant compared to others you know on the following characteristics. Please place a check mark in every category.

	Outstanding	Above average	Average	Below average	Cannot evaluate
Attendance & punctuality					
Emotional stability					
Personal integrity & accountability					
Ability to relate to co-workers					
Ability to incorporate constructive criticism					
Ethical conduct					
Sense of responsibility					
Recognition of own limits					
Ability to keep material confidential					
Problem solving skills					
Oral communication skills					

3. Recommendation – I recommend this applicant for the Licensed Practical Nursing Program ___Yes ___No

   Additional comments may be added to the back of this form.

4. The above recommendation is based on my best judgment. I am willing to answer additional questions concerning this evaluation if the Practical Nursing Department deems it necessary.

   Signature_______________________________________ Date__________________________

   Directions: hand-deliver to the Allied Health Office, or mail the completed form to:

Allied Health Office
Ozarks Technical Community College
1001 East Chestnut Expressway
Springfield, MO 65802-3625

6/24/10
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