

# School of Medical Technology

## Letter of Recommendation

Student name \_\_\_\_\_

Course Num: \_\_\_\_\_

### Right of access to the information

I waive my right to know the content of this letter of recommendation.

I do not waive my right to know the content of this letter of recommendation.

Student 's signature \_\_\_\_\_

**To the evaluator:** Write the number that best describes each statement.

### I can truthfully say...

	Exceptional 5	Excellent 4	Good 3	Average 2	Poor 1	Not applicable 0
Leadership						
Intellectual capacity						
Motivation and perseverance to reach his/her goals						
Ability to carry out independent work						
Capacity to work in groups						
Laboratory skills						
Analytical ability						
Ability to cope under stressful, unusual or difficult situations						
Reading comprehension in english						
Works accurately and without delay						
Probability of success in our program						

### Evaluator Information:

Name: \_\_\_\_\_

Institution: \_\_\_\_\_

Email: \_\_\_\_\_

Phone number: \_\_\_\_\_

Signature: \_\_\_\_\_

Please fill out this form and send it to:

[tecmed@pucpr.edu](mailto:tecmed@pucpr.edu)  
or

Pontifical Catholic University of Puerto Rico  
School of Medical Technology  
Admissions Committee  
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