REFERENCES

Please list three people who would be willing and able to provide us with information regarding your academic ability, personal characteristics, sense of values, and potential for success as an allied health care professional. At least one of your sponsors must be a health care professional. Ask each of your sponsors to complete the attached recommendation form and return it directly to the address on the form .References cannot be relatives.

Sponsor 1
Position/Title_____

Address_____
(street) (city)
_____
(state) (zip)

Sponsor 2
Position/Title_____

Address_____
(street) (city)
_____
(state) (zip)

Sponsor 3
Position/Title_____

Address_____
(street) (city)
_____
(state) (zip)

ATHLETIC TRAINING PROGRAM RECOMMENDATION FOR ADMISSION

PART A. To be completed by the applicant. Please print or type.

APPLICANT'S FULL NAME -

_____

LAST NAME FIRST NAME MIDDLE NAME

Under the provisions of the Family Education Rights and Privacy Act of 1974, you (if admitted and enrolled) will have access to the information provided unless you have waived such access. Please sign and date below to inform us of your decision.

I hereby waive my right of access to the information recorded below.

_____

Signature of Applicant Date

OR

I do not waive my right of access to the information recorded below.

_____

Signature of Applicant Date

PART B. To be completed by the evaluator.

To the Evaluator: You have been referred to us as one who knows the applicant above. The proper selection of applicants for the athletic training program is important, not only to Albion College, but to the public as well. The athletic training faculty relies on you to act as an extension of our admissions committee. In order to be fair to all applicants we need as much information as you can provide. Your recommendation will be most useful if you include an evaluation of the applicant's strengths AND weaknesses.

When you have completed this recommendation form, please seal it in an envelope, sign your name across the flap, and return it directly to Robert Moss PhD, ATC, Box 4830 611 E. Porter, Albion College, Albion, MI 49224.

RECOMMENDER'S NAME -

_____

LAST NAME FIRST NAME TITLE/POSITION

ADDRESS -

_____

(STREET) (CITY)

_____

(STATE) (ZIP) (BUSINESS PHONE)

1. HOW MANY YEARS AND IN WHAT CAPACITY HAVE YOU KNOWN THE APPLICANT?

2. PLEASE COMMENT ON THE APPLICANT'S ACADEMIC STRENGTHS AND WEAKNESSES. SPECIFICALLY, HOW WELL DOES THE APPLICANT WRITE AND SPEAK? HOW LIKELY IS THE APPLICANT TO SUCCEED ACADEMICALLY IN A PROGRAM THAT REQUIRES A SIGNIFICANT AMOUNT OF OUT-OF-CLASSROOM TIME?

3. HEALTH CARE PROFESSIONS LIKE ATHLETIC TRAINING REQUIRE AN EXTRAORDINARY COMMITMENT TO WORK WITH PEOPLE AND THEIR PROBLEMS. PLEASE COMMENT ON THE APPLICANT'S EMOTIONAL MATURITY, VALUES DEVELOPMENT, PERSEVERANCE, AND OTHER PERSONALITY CHARACTERISTICS THAT WILL HELP US EVALUATE THEIR READINESS FOR THIS PROGRAM.

4. WHAT EVIDENCE CAN YOU PROVIDE THAT THE APPLICANT HAS CAREFULLY AND THOUGHTFULLY CONSIDERED THE ADVANTAGES AND DISADVANTAGES OF A CAREER IN ATHLETIC TRAINING? HOW SERIOUS IS THE APPLICANT ABOUT ATHLETIC TRAINING?

_____

Signature Date

Thank you for taking the time and effort to complete this recommendation. After sealing it in an envelope and signing the flap, please mail it directly to:

Robert Moss, PhD, ATC, Box 4830 611 E. Porter, Albion College, Albion, MI 49224.