To:

________________________________________________________        _____________________
name of recipient                                   date

Relationship to applicant:            immediate supervisor              school of nursing faculty               other (explain below)
___________________________________________________________________________________________

How long has the recipient known the applicant? ________________________________________________________

________________________________________________________            __________________
signature of applicant                     date

has applied for admission to the University of Michigan-Flint Hurley Medical Center Doctor of Nurse Anesthesia Practice program for registered nurses. The Anesthesia Program Admissions Committee would appreciate your assistance in determining the applicant’s potential for success both as a student and as a future nurse anesthetist. Please return the completed appraisal to the address above, as the application is considered incomplete until the University receives this form. Your personal letter is a welcome addition. All appraisals are held in confidence.

Thank you,
Shawn Fryzel, CRNA, DrAP
Director, University of Michigan-Flint Anesthesia Program

Relationship to applicant:            immediate supervisor              school of nursing faculty               other (explain below)
___________________________________________________________________________________________

How long has the recipient known the applicant? ________________________________________________________

________________________________________________________            __________________
signature of applicant                     date

please continue on page 2
Please check the appropriate rating for each of the following traits.

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<tr>
<th>Trait</th>
<th>OUTSTANDING TOP 5%</th>
<th>GOOD TOP 25%</th>
<th>AVERAGE TOP 50%</th>
<th>BELOW AVERAGE</th>
<th>INSUFFICIENT KNOWLEDGE TO RATE</th>
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<td>HONESTY</td>
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<td>REACTION UNDER STRESS</td>
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1. Have you ever known the applicant to abuse drugs or alcohol?  
   - [ ] YES  
   - [ ] NO

2. What are the applicant’s strengths?

3. What are the applicant’s weaknesses?

4. What is your overall recommendation regarding the applicant?

5. Would you be comfortable with this individual taking care of your critically ill patient?  
   - [ ] YES  
   - [ ] NO

Recipient Information:

Signature ___________________________________________  Date _________________________________

Name (printed) _________________________________________  Title _________________________________

Organization _________________________________________  Dept. ________________________________

City _________________________________________________  State _____________  Zip_______________

Phone (daytime) ________________________________________  Email ____________________________________