To:

________________________________________________________ ____________________
NAME OF RECIPENT                                    DATE

________________________________________________________ ____________________
NAME OF APPLICANT

The above-named individual has applied for admission to the University of Michigan-Flint Doctor of Nurse Anesthesia Practice (DNAP) 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,
Gena Welch, DrAP, CRNA
Director, University of Michigan-Flint Nurse Anesthesia Program

Relationship to applicant:                                  IMMEDIATE SUPERVISOR  SCHOOL OF NURSING FACULTY  OTHER (EXPLAIN BELOW)

__________________________________________________________________________________________

How long has the recipient known the applicant? ____________________________

__________________________________________________________________________________________

please continue on page 2

APPLICANT:

I APPROVE THIS REQUEST FOR INFORMATION AND WAIVE MY RIGHT TO INSPECT THE RECIPIENT’S COMPLETED REMISSION.

________________________________________________________ ____________________
SIGNATURE OF APPLICANT                                    DATE
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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<td>GETS ALONG WITH OTHERS</td>
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<td>PROBLEM SOLVING/CRTICAL THINKING</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 ___________________________