



DIETETIC INTERNSHIP RECOMMENDATION FORM

To the Applicant: Please complete the following page and print (or type) your name and the evaluator's name at the bottom of pages 2 and 3.

Name: _____ Date of Graduation: ____/____/____

The applicant should sign and date one of the following statements:

1. I wish to have access to this letter, and I understand that under the Family Education Rights to Privacy Act of 1974, 20 U.S.C.A. Par. 1323 g (a) (1) and P.L. 397 of 1978, I have the right to read this recommendation.

Applicant's Signature: _____ Date: ____/____/____

2. I wish this letter to be confidential, and I hereby waive any and all access rights granted me by the above laws to this recommendation.

Applicant's Signature: _____ Date: ____/____/____

Name of Evaluator: _____

- Please indicate type of recommendation: [] Academic, [] Personal, [] Professional - Employment

This form (3 pages) is to be sent to Virginia Pelegrin, postmarked no later than February 8, 2008.

Mail to the applicable address: Regular Mail, North Oaks Health System, Nutritional Services Department, P.O. Box 2668, Hammond, LA 70404, ATTN: Virginia Pelegrin, MPH, LDN, RD, Internship Director

Overnight Mail/Shipment, North Oaks Medical Center, Nutritional Services Department, 15790 Paul Vega, MD, Drive, Hammond, LA 70403, ATTN: Virginia Pelegrin, MPH, LDN, RD, Internship Director

For more information, please call (985) 230-6606.

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To the Evaluator: Please rate the applicant on the qualities that you feel you can judge on the grid below. In the next section, please provide narrative discussion of your ratings.

- KEY**
- O = Outstanding
 - MS = More than Satisfactory
 - SAT = Satisfactory
 - NI = Needs Improvement
 - U = Unsatisfactory
 - NO = Not Observed or
No Basis for Judgment

	O	MS	SAT	NIB	U	NO
Analytical Skills						
Application of Knowledge						
Communication Skills (Oral)						
Communication Skills (Written)						
Interpersonal Skills (Peers/Coworkers)						
Interpersonal Skills (Teachers/Supervisors)						
Leadership Potential						
Initiative						
Reaction to Stress						
Assumes Responsibility						

1. Relationship to Applicant: Advisor Major Professor Work Supervisor
 Other (*Please indicate.*): _____
2. How long have you known the applicant? _____
3. How well do you know the applicant? _____
4. Do you wish to? Highly Recommend Recommend Not Recommend

Signature: _____ Date: ____/____/____

Position (if applicable): _____

Address/Phone Number: _____

Name of Applicant: _____

Name of Evaluator: _____



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Additional Information: Use this space to amplify or add to characteristics rated on page 2. Please indicate the applicant's strengths and those qualities that require further development (*may use additional sheet*).

Strengths: _____

Qualities That Require Further Development: _____

Name of Applicant: _____

Name of Evaluator: _____