

OKLAHOMA SCHOOL OF MEDICAL TECHNOLOGY/CLINICAL LABORATORY SCIENCE

STUDENT ACADEMIC EVALUATION FORM

NAME OF STUDENT (Please print name in full): _____

I. SCHOLASTIC ABILITY

A. Where would you rank this applicant with those currently in your department/class? Please indicate ranking criteria: class () department () other ()

LOWER 1/3 () MID 1/3 () UPPER 1/3 ()

B. In your opinion, is the applicant's scholastic record an accurate index?

YES () NO () DON'T KNOW ()

ADDITIONAL COMMENTS:

II. PERSONAL APPRAISAL

A. How long have you known this applicant? () less than 1 year () 2-3 years () 3 or more years

In what capacity? () Instructor - List course(s)._____ () Advisor

B. Rate the applicant on the following qualifications, in comparison to other students in classes.
(5 = Outstanding; 3 = Average; 1 = Poor)

| 5 | 4 | 3 | 2 | 1 | Not Observed | |
|-------|-------|-------|-------|-------|--------------|---------------------------------|
| _____ | _____ | _____ | _____ | _____ | _____ | Psychomotor |
| _____ | _____ | _____ | _____ | _____ | _____ | Manual dexterity |
| _____ | _____ | _____ | _____ | _____ | _____ | Laboratory skills |
| _____ | _____ | _____ | _____ | _____ | _____ | Safe practices |
| _____ | _____ | _____ | _____ | _____ | _____ | Accuracy of results |
| _____ | _____ | _____ | _____ | _____ | _____ | Cognitive |
| _____ | _____ | _____ | _____ | _____ | _____ | Academically competent |
| _____ | _____ | _____ | _____ | _____ | _____ | Written expression |
| _____ | _____ | _____ | _____ | _____ | _____ | Oral expression |
| _____ | _____ | _____ | _____ | _____ | _____ | Critical thinker/problem solver |
| _____ | _____ | _____ | _____ | _____ | _____ | Affective |
| _____ | _____ | _____ | _____ | _____ | _____ | Motivation |
| _____ | _____ | _____ | _____ | _____ | _____ | Cooperation with other |
| _____ | _____ | _____ | _____ | _____ | _____ | Adaptable/flexible to change |
| _____ | _____ | _____ | _____ | _____ | _____ | Follows instructions |
| _____ | _____ | _____ | _____ | _____ | _____ | Emotional stability |
| _____ | _____ | _____ | _____ | _____ | _____ | Leadership skills |

C. Overall recommendation:

_____ Highly Recommended

_____ Recommended with Reservations

_____ Recommended

_____ Not Recommended

NAME: _____

TITLE: _____

SIGNATURE: _____

DATE: _____

INSTITUTION: _____

**PERMISSION TO RELEASE PERSONALLY IDENTIFIABLE AND/OR
WAIVER OF RIGHT TO INSPECT OR REVIEW CONFIDENTIAL LETTER OF RECOMMENDATION
(FAMILY EDUCATION RIGHTS AND PRIVACY ACT OF 1974, AS AMENDED)**

I, _____, () do () do not hereby waive and renounce all right of access, including those established by the Family Education Rights and Privacy Act of 1974, to any letter or letters of reference or confidential letters of recommendation to be hereafter written in my behalf by:

_____ (Name of person asked to write recommendation)

Furthermore, I grant the above named person permission to release specific and personally identifiable information about me from my educational record in order that he/she may fulfill my request to write a letter of recommendation. He/she may release to the party or parties named below:

- () any such information he/she may release, or
- () only the information listed on the reverse side.

The above named person may also release the information verbally to the party or parties listed below.

This waiver is not operative and becomes null and void if at any time said letter or letters of reference or confidential recommendations are used for any purpose other than these which are specifically intended. My specific intention is:

- () respecting admission to an educational agency or institution
- () other (specify): _____

A letter of recommendation and a student academic evaluation form must be sent to: Program Director, School of Medical Technology, for the school indicated below:

_____ Comanche County Memorial Hospital Laboratory; Stacey Paryag, MPA, AHI(AMT), MLS(ASCP)^{CM}; Program Director; 3401 West Gore Boulevard, Lawton, OK 73505; Phone: (580) 355-8699, ext 4762; Fax: (580) 585-5462

_____ Mercy Hospital Ada Laboratory; Leah Babcock, MSHR, MT(ASCP); Program Director; 430 North Monte Vista, Ada, OK 74820; Phone: (580) 421-1596; Fax: (580) 421-1525

_____ Mercy Hospital Ardmore Laboratory; Karen Ford, MBA, MT(ASCP)BB; Program Director; 1011 14th Avenue, N.W., Ardmore, OK 73401; Phone (580) 220-6339; Kari Butler, MLS, AMT; Program Educator; Phone: (580) 220-6063; Fax: (580) 220-580-6205

_____ Saint Francis Hospital Laboratory; Nathaniel D. Harden, MS, MLS(ASCP); Program Director; 6161 South Yale Avenue, Tulsa, OK 74136-1902; Phone: (918) 494-6342; Fax (918) 494-1497

Signature of Waiving Party (Applicant)

Date