Inova Fairfax Hospital
Residency Applicant Recommendation Request Form

Applicant: Please give this form to each person providing a reference for you. They should complete this form in addition to writing a letter of recommendation**.**

To be completed by applicant (please print or type):

Name of applicant: _____
First MI Last Name

_____
Street address or PO Box

_____
City State Zip

I waive the right to review this recommendation.

_____
Signature of Residency Applicant

To the recommendation provider:

Please complete and return this form by **January 3** to:

Anna M Wodlinger Jackson, PharmD, BCPS
Residency Program Director
Inova Fairfax Hospital
Department of Pharmacy
3300 Gallows Rd
Falls Church, VA 22042

Applicants are required to have recommendations submitted in a letter format by persons who are in a position to evaluate their qualifications for residency training. The recommendation provider is asked to make a frank appraisal of the applicant's character, personality, abilities and suitability for a pharmacy residency. Recipients of this information are asked to keep it confidential.

In addition to a letter of recommendation, please complete the following:

(1) I have known the applicant for approximately _____ (months) (years)
(2) My relationship to the applicant was (or is) in the following capacity:
___faculty advisor _____clerkship preceptor _____other faculty relationship _____employer
___supervisor _____other:_____

(3) I know him/her ____very well ___fairly well ___only casually

(4) Please rank the applicant's suitability as a resident:
☐ I highly recommend this applicant/"must interview"
☐ I recommend this applicant/"should interview"
☐ I recommend this applicant, but with some reservation/"consider interview"
☐ I am not able to recommend this applicant/"no interview"

_____
Signature of Recommender

_____
Name

_____
Title/affiliation

_____
Address

_____
Phone number or email