

**LETTER OF EVALUATION  
HONORS COMBINED BS/ DMD PROGRAM  
COLLEGE OF DENTISTRY**

**INSTRUCTIONS:** Applicant must complete Part A of this form, sign it, and present it to the person from whom they are requesting an evaluation. The evaluator should complete Part B and return the form to the: **College of Dentistry, Office of Admissions, P.O. Box 100445, University of Florida, Gainesville, FL 32610-0445.**

**PART A (please print)**

NAME: \_\_\_\_\_ Social Security Number \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip)

I agree that the recommendation I am requesting shall be held in confidence by officials of the University of Florida, College of Dentistry, and I hereby waive any rights I may have to examine it.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**PART B**

- In what capacity have you been associated with the applicant?  
Instructing: ( ) Lecture, ( ) Lab, ( ) Seminar, ( ) Individual work, ( ) Other,  
(Specify) \_\_\_\_\_
- How well do you know the applicant? ( ) Very well, ( ) Fairly well, ( ) Slightly
- How long have you known the applicant? \_\_\_\_\_ yrs. \_\_\_\_\_ mo.
- Do you know of any disciplinary action (academic or legal) involving this candidate or any reason to question the applicant's integrity which might indicate unsuitability for a professional career? ( ) Yes, ( ) No. If yes, please provide a full explanation in the Narrative Comments section or in a letter.
- Please indicate your evaluation of the applicant with respect to those traits you have observed. You are asked to rank the applicant solely with reference to other students preparing for the dental profession that you have known. Make specific comments where appropriate.

**STANDARDS USED IN RANKING ITEMS BELOW:** 1-Outstanding, top 5%; 2-Excellent, upper 15%; 3-Very Good, upper third; 4-Good, middle third; 5-Fair, lower third; 6-Poor, lower 10%; Leave blank if you have no basis for judgment. Please check factors that you consider to be the candidate's major strengths (S) and weaknesses (W).

EVALUATION FACTORS	1	2	3	4	5	6	S	W	SPECIFIC COMMENTS
<b>MOTIVATION:</b> Genuineness and depth of commitment to dentistry.									
<b>MATURITY:</b> Personal development, ability to cope, reaction to criticism.									
<b>EMOTIONAL STABILITY:</b> Performance under pressure, constancy in ability to relate to others.									
<b>INTERPERSONAL RELATIONS:</b> Ability to get along with others, rapport, cooperation, attitudes toward supervision.									
<b>EMPATHY:</b> Sensitivity to feelings and needs of other, consideration, tact, compassion, concern.									
<b>JUDGMENT:</b> Ability to analyze a problem, common sense, decisiveness, interpretation of results.									
<b>RELIABILITY:</b> Dependability, sense of responsibility, promptness, conscientiousness.									
<b>COMMUNICATION SKILLS:</b> Clarity of expression, articulateness, use of written English.									
<b>SELF CONFIDENCE:</b> Assuredness, capacity to achieve with awareness of own strengths, independence.									
<b>MANUAL DEXTERITY:</b> Coordination, steadiness, observed practical experience.									
<b>INTELLECTUAL ABILITY:</b> Ease of comprehension, retention, curiosity, depth of understanding.									

6. NARRATIVE COMMENTS: PLEASE TYPE OR PRINT USING BLACK INK FOR EASE IN COPYING.

7. Check your overall evaluation of the applicant for dental school relative to all students preparing for the same profession whom you have known.

- Outstanding Candidate, top 5%
- Excellent Candidate, upper 15%
- Very Good Candidate, upper third
- Good Candidate, middle third
- Fair Candidate, lower third
- Poor Candidate, lower 10%

All "Letter of Evaluation" forms are destroyed at the completion of each application processing period in compliance with the Office of Admissions and Records nonessential documents retention and destruction policy.

Signature \_\_\_\_\_ Title \_\_\_\_\_

Evaluator's Name (Print) \_\_\_\_\_ Dept \_\_\_\_\_

Date \_\_\_\_\_ Institution \_\_\_\_\_

Address \_\_\_\_\_  
(Street, Bldg., Room) (City) (State) (Zip)

\*If teaching assistant, please have this evaluation endorsed below by the faculty member in charge.

\_\_\_\_\_  
(Signature) (Title) (Date)

RETURN TO: COLLEGE OF DENTISTRY, OFFICE OF ADMISSIONS, P.O. BOX 100445,  
UNIVERSITY OF FLORIDA, GAINESVILLE, FL 32610-0445