



**EVALUATION FORM
HOSPITAL OF SAINT RAPHAEL
SCHOOL OF NURSE ANESTHESIA**

Date: _____

To: Director / Dean, College of Nursing

We are considering _____, a graduate of your College of Nursing, for admission to the Graduate Program in Nurse Anesthesia. As we attach considerable significance to education and professional references in our selection process, your assistance in completing and returning this form would be appreciated. The information requested will be kept in strict confidence.

Date of Enrollment: _____

Date of Graduation: _____

Did the applicant complete your program in the normally prescribed length of time?

If not, please explain. _____

Did the applicant receive any special awards or recognition in your program?

If yes, please specify. _____

Did the applicant present any specify problems or require any special attention while in your program? _____ If yes, please specify,

EVALUATION OF APPLICANT:

CRITERION	Poor	Fair	Average	Good	Excellent
1. General quality of work	()	()	()	()	()
2. Ability to get along with others	()	()	()	()	()
3. Response to Supervision	()	()	()	()	()
4. Attitude	()	()	()	()	()
5. Attendance & Punctuality	()	()	()	()	()
6. Professional demeanor	()	()	()	()	()

Do you feel those the applicant's grades and / or other assessments accurately and completely reflect the applicant's abilities? _____ If not, please specify,

Do you have any hesitations about recommending this applicant to our program?

_____ If yes, please specify,

Additional remarks:

Date: _____

Signature: _____

Phone: _____

Title: _____

PLEASE RETURN TO:

Program Director
Hospital of Saint Raphael
School of Nurse Anesthesia
1423 Chapel Street
New Haven, CT 06511