



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

Date \_\_\_\_\_

To: Supervisor / Unrelated Physician or Professor

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We are considering \_\_\_\_\_, for admission to the Graduate Program in Nurse Anesthesia. 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.

How long have you known the applicant: \_\_\_\_\_

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 have any hesitations about recommending this applicant to our program? \_\_\_\_\_  
If yes, please specify.

Signature: \_\_\_\_\_ Phone: \_\_\_\_\_  
Title: \_\_\_\_\_

**Please return to:**  
Program Director  
Hospital of Saint Raphael  
School of Nurse Anesthesia  
1423 Chapel Street  
New Haven, CT 06511