

**Pathways to Inclusive Health Care (PIHC) Scholarship Program  
Shriver Center/University of Massachusetts Medical School  
55 Lake Avenue North, Worcester, MA 01655  
TEL: (774)-455-6552  
FAX: (774)-455-6565**

### **Professional Reference**

(Please type or print)

**Name of Applicant:**

**Evaluator's Position/Title:**

**Name of Evaluator:**

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**To the Applicant:**

This recommendation will become part of your file. It will be used only for consideration for acceptance into the Pathways to Inclusive Health Care (PIHC) Scholarship Program and will not be disclosed to any unauthorized individual without your consent. If accepted into the program, you will be accorded access to the contents of this recommendation unless you voluntarily waive your right of access. ***Please check one of the following boxes and sign the statement below.***

I have read the information above and I hereby:           waive           do not waive   my right of access to this document should I be accepted into the PIHC Program.

Signature:

Date:

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**To the Evaluator:**

The above-named individual is applying for the one-year Pathways to Inclusive Health Care (PIHC) Scholarship Program at the Shriver Center. PIHC is an innovative, grant-funded, gap year program that provides college graduates who are considering a career in a health-related field to gain experience working with individuals with disabilities.

Please assist us in the application process by responding to the attached reference questions to the extent to which you have knowledge of the applicant. Your personal knowledge of the applicant will be helpful in assisting us to select qualified individuals who will be able to benefit from and succeed in this program.

Under the 1974 Family Educational Rights and Privacy Act, the applicant named above will have access to this recommendation unless he/she has waived that right. Please note that your reply is confidential if the applicant has signed the waiver (see above). We would appreciate your honest and candid feedback about this applicant and thank you in advance for your time in completing this reference.

**Name of Applicant:**

**Name of Evaluator:**

**1. How long and in what capacity have you known the applicant?**

**2. Please give us your opinion about the individual’s abilities, strengths and weaknesses in the areas listed below. Citing specific examples that illustrate your views about this individual would be most helpful.**

|  | Excellent                | Above Average            | Average                  | Below Average            | Unable to Judge          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Initiative and motivation  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Self-reliance and independence   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reliability and follow-through   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Maturity   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Flexibility and adaptation to change   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Problem solving skills   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Social sensitivity   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Interpersonal skills and ability to work with others who have different viewpoints | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Growth during total period of observation  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Active pursuit of learning and demonstration of intellectual curiosity             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Written and verbal skills  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Comments:**

3. Please add any information and make any additional comments that you feel are important for us to understand this individual's strengths and weaknesses and ability to succeed in the Pathways to Inclusive Health Care Scholarship Program.

Signature:

Evaluator's Name:

Title:

Address:

Telephone Number:

**Mail to:**

Pathways to Inclusive Health Care Scholarship Program  
Attn: Susan Swanson, MA, CCC-SLP  
Shriver Center/University of Massachusetts Medical School  
55 Lake Avenue North, Worcester, MA 01655  
TEL: (774)-455-6552  
FAX: (774)-445-6565  
[susan.swanson@umassmed.edu](mailto:susan.swanson@umassmed.edu)

*Thank you for your time and attention in completing this reference.*