

SCHOOL OF NURSE ANESTHESIA  
**EVALUATION FORM**

Date: \_\_\_\_\_

To: Dean of 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 specific problems or require any special attention while in the program? \_\_\_\_\_

*If yes, please specify.* \_\_\_\_\_  
\_\_\_\_\_

**EVALUATION OF APPLICANT**

<b>CRITERION</b>	<b>Poor</b>	<b>Fair</b>	<b>Average</b>	<b>Good</b>	<b>Excellent</b>	<b>Exceptional</b>
General quality of work						
Critical thinking skills						
Relationships with peers/faculty/members of medical team						
Response to supervision						
Emotional intelligence/maturity						
Attendance/punctuality						
Professional demeanor/accountability						

Do you feel that the applicant's academic record and /or other assessments accurately and completely reflect the applicant's abilities? \_\_\_\_\_ *If not, please specify.*

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Do you have any hesitation about recommending this applicant to our program? \_\_\_\_\_

*If yes, please specify.* \_\_\_\_\_

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If applicable, please add any additional information re: the candidate here:

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Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

**Please return this completed form to:**

Program Director  
YNHH School of Nurse Anesthesia  
1450 Chapel Street – MOB 216  
New Haven, CT 06511-4405