

Schmitt Program on Integrative Brain Research
Application for Medical Student Summer Research Fellowships
Reference Report on Applicant

Name of Applicant _____
Last (Surname) First Middle

Year of medical class _____

If you agree to waive your right under the Family Education Rights and Privacy Act of 1974 to review specific and composite letters of recommendation, please sign here:

Applicant's Signature _____ Date _____

Complete this form on the candidate noted above. If additional space is required, use university or business letterhead.

1. How long have you known the applicant? _____ In what capacity? _____

2. The Admissions Committee will be very grateful for your estimate of the applicant's preparation, aptitude, and creativity for independent work and likelihood of succeeding in an academic career.

3. Please comment on the applicant's motivation, maturity, self-confidence, and strength of commitment as it relates to the Program and chosen career path.

4. Among the students at a similar level whom you have taught in recent years, how would you rate this student?

Among the very best Top 5% Top 10% Top quarter Average

Signature _____ Date _____

Name of recommender (please print) _____

Position, profession or occupation _____

E-mail address _____ Phone (_____) _____

Professional address _____

