RECOMMENDATION REQUEST FOR DRUG INFORMATION
RESIDENCY APPLICATION

APPLICANT'S NAME: _____

_____ I waive the right to review this recommendation.

_____ I do not waive the right to review this recommendation.

_____ _____
Applicant Signature Date

REFERENCE:

Name: _____ Title: _____

Institution: _____

_____
Mailing Address

_____ _____ _____
City State Zip

Phone: _____ E-Mail: _____

Attach a letter of recommendation that addresses the following points:

- How well and in what capacity do you know the applicant?
- How does this applicant rate with regard to others with similar training (e.g., among best, average, among worst)?
- What special strengths do you feel the applicant possesses?
- How would you evaluate the candidate's communication skills (verbal & written) and interpersonal skills?
- Are there any areas of weakness that must be addressed?
- Do you believe the applicant will be successful in this residency? Why or why not?

Please complete and return by February 23. Thank you.

Return To: Marie A. Abate, PharmD
Drug Information Residency Coordinator
Professor of Clinical Pharmacy
West Virginia University
School of Pharmacy
PO Box 9520
Morgantown, WV 26506-9520

E-mail: mabate@hsc.wvu.edu