

**Northern Michigan University**  
**Department of Nursing**  
**Master of Science in Nursing**  
**Family Nurse Practitioner Program**  
**2301 New Science Facility**  
**Marquette, Michigan 49855**  
**Phone: (906) 227-2833 Fax: (906) 227-1658**

**Recommendation Form**

**MSN Applicant:** Please complete this portion of the recommendation form and forward it to the person who will submit a letter of recommendation. Please provide them with an envelope that is stamped and addressed to the MSN Program

Applicant's Name	
Address	
City/State/Zip	
Name of the person completing the recommendation	

This recommendation will not be considered unless you (the applicant) signs one of the statements below. The family Education and Privacy Act of 1974 gives the student the right to inspect letters of recommendation written in support of applications for admission or fellowship. The law also permits students to waive that right if they choose, although such a waiver cannot be a condition of admission or award.

<input type="checkbox"/> The undersigned hereby waives any right to inspect the recommendation submitted by the person to whom this form is being given to.	<input type="checkbox"/> The undersigned, if admitted to graduate study in the Family Nurse Practitioner Program, reserves the right after enrollment to inspect the recommendations submitted by the person to whom this form is being given.
<hr style="width: 80%; margin: 0 auto;"/> Signature <span style="margin-left: 150px;">Date</span>	<hr style="width: 80%; margin: 0 auto;"/> Signature <span style="margin-left: 150px;">Date</span>

**TO BE COMPLETED BY THE RECOMMENDER: PLEASE RESPOND TO THE FOLLOWING QUESTIONS:**

1. How long have you known the applicant and in what connection?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
2. What do you consider to be the applicant's strengths?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
3. What do you consider to be the applicant's weaknesses?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PLEASE RATE THE APPLICANT IN THE FOLLOWING AREAS:					
	Poor	Average	Good	Excellent	Unable to Evaluate
1. Critical Thinking					
2. Clinical knowledge and skills					
3. Health assessment skills					
4. Decision-making skills					
5. Interpersonal Skills					
6. Ability to work with others					
7. Communication skills (oral)					
8. Writing ability					
9. Analytical ability					
10. Creativity					
11. Professionalism					
12. Level of independence					
13. Accountability					

Please comment on the ratings that you have assigned above and make any additional comments about the applicant's personal and professional qualities.

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Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

Title \_\_\_\_\_

Institution \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Email \_\_\_\_\_

*Thank you for completing the recommendation form.  
Please return this form directly to the MSN Program.*