UNIVERSITY OF SINT EUSTATIUS
SCHOOL OF MEDICINE

LETTER OF RECOMMENDATION REQUEST

Applicant: ____
Last: First MI SSN (US) or SIN (CAN)
Address: ____

This individual is applying to the University of Sint Eustatius School of Medicine as a Medical Doctor degree candidate. It would be greatly appreciated if you could complete this form or write a letter of support for this applicant, as an application will not be considered complete without the inclusion of recommendations.

Student Waiver: I, the undersigned, request that this recommendation be kept in confidence and sent directly to the University of Sint Eustatius School of Medicine.

Student Signature: ______________________________Date: ______/______/______

I have known the applicant for ________________________years.

In what capacity do you know the applicant? ____

____

Please rate the applicant in the following categories:

	Upper 10%	Upper 25%	Average	Below Average	Unknown
Scholastic Aptitude:					
Sciences					
All Subjects					
Motivation:					
Self Confidence					
Oral Communication					
Written Communication					
Working with Others					
Personality – Sense of Humor					

Please attach a letter if you wish to add any additional comments that might support this applicant for admission to our Medical Doctor Degree program.

Signature:______________________________Date:______________________________

Name:______________________________Title:______________________________
Please print or Type

Address: ____
Street: City: State/Province Zip/Postal Code

____
Day Phone: Evening Phone: Email:

Please Mail, Fax or Email this Letter of Recommendation to:

University of Sint Eustatius School of Medicine -- Admissions Department
Suite 215-- 6901 Jericho Turnpike -- Syosset --New York -- 11791
Fax: 516-656-9262
Email: admissions@eustatiusmed.edu