CHILD LIFE STUDENT RECOMMENDATION FORM

Applicant Name: _____ **Date:** _____

Your Name: _____

Your Relationship to Applicant: _____

May we contact you for further information? Y / N

Phone #: _____

Email: _____

The above individual has applied for acceptance into the Child Life student program at Blank Children's Hospital. Please evaluate this individual in the following areas:

	Weak	Below Average	Average	Above Average	Out-standing
1. Maturity					
2. Problem solving skills					
3. Ability to accept feedback & constructive criticism					
4. Functions responsibly and independently					
5. Motivation to learn					
6. Interpersonal skills: Adults					
Children					
7. Communication skills: Adults					
Children					
8. Displays motivation and initiative					
9. Is adaptable/flexible					
10. Is punctual, prompt and reliable					

Please share with us why you are recommending this individual. What contributions do you feel they will make to the field of Child Life?