



*Remarkable People. Remarkable Medicine.*

Employment and Recruitment Department  
1918 Randolph Road  
Suite 830  
Charlotte, NC 28207

(704) 384-4832

**Re: Recommendation for** \_\_\_\_\_

Dear Faculty Member:

The student listed above has requested a recommendation from you that can be forwarded to the Employment Department at Novant Health using the attached stamped pre-addressed envelope. The information you share with us will be used to assist with making decisions to afford the best transition for the student from the academic to the work environment. Further, the information shared will help with placing the student in the most appropriate work setting. Our goal is to make the student's transition into practice a successful one.

We thank you for completing the attached recommendation.

Sincerely,

*Bethanne Mascilak*

Nurse Recruitment  
Novant Health Southern Piedmont Region

## PERSONAL RECOMMENDATION

Note to student requesting recommendation: Please enter your name on the line marked "Name of student requesting information" and deliver or mail to the faculty member who will write this recommendation. Complete A or B below. Ask that the recommendation be mailed using the stamped, pre-addressed envelope. Two letters of recommendation from faculty are needed. Appropriate faculty sources to request a recommendation from include faculty who have led you in clinical or instructional experiences. Please use this form only.

**Name of student requesting recommendation:** \_\_\_\_\_  
Last
First
Middle

**A.** I authorize the release of a candid recommendation in order to assist with the hiring process. I understand the information below will be kept confidential both from me and the public. I waive any rights or access that I might have by law. I further understand that Novant Health does not require me to execute this waiver and is willing to review my application without such a waiver.

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

**B.** I authorize the release of a candid recommendation, but I choose not to waive my right to examine this recommendation.

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

Note to faculty member making recommendation: The student whose name appears above is requesting you to complete the recommendation below. We would appreciate your assessment of the student according to the questions asked on this form. If you will be unable to assess this student in more than half of the categories listed in the table below, please contact him/her so he/she can ask for a recommendation from someone who is able to assess him/her in the majority of the categories listed. Please mail the recommendation using the attached stamped, pre-addressed envelope.

**How would you rate the person above as compared with the college/university nursing student population with whom you are acquainted?**

	Outstanding (top 5% of class)	Excellent (top 15% of class)	Good (top third of class)	Average (middle third of class)	Poor (bottom third of class)	No basis for assessment
<b>Academic</b>						
Intellectual Ability						
<b>Professional</b>						
Overall clinical performance						
Critical thinking						
Priority setting						
Multi-tasking						
Leadership						
Time management						
Flexibility						
Ability to organize work						
Attention to detail						
Commitment to profession						
Ability to work under stress						
<b>Personal</b>						
Maturity						
Initiative						
Ability to work with others						
Communication skills						

**What do you consider to be this student's talents or strengths?** \_\_\_\_\_

**What do you consider to be this student's areas of weakness or areas in need of improvement?** \_\_\_\_\_

**Which areas would you recommend this student for any of the following clinical practice areas (please check all that apply)?**

<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Intensive Care	<input type="checkbox"/> Mother-Baby
<input type="checkbox"/> Cardiac Telemetry	<input type="checkbox"/> Intermediate Care	<input type="checkbox"/> Neonatal Intensive Care
<input type="checkbox"/> Coronary Care	<input type="checkbox"/> Labor and Delivery	<input type="checkbox"/> Operating Room
<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Oncology
<input type="checkbox"/> GYN	<input type="checkbox"/> Medical-Surgical	

**General comments:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Name (please print):** \_\_\_\_\_

**Title:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **School:** \_\_\_\_\_