



Department of Biochemistry and Molecular Biology  
 University of Arkansas for Medical Sciences  
 Summer Research Program Recommendation Form

TO THE APPLICANT: Complete this part of the form, then give it to the evaluator and have them complete the form and return it directly to the Department of Biochemistry & Molecular Biology.

Applicant Name: \_\_\_\_\_

I understand that federal legislation provides me with the right of access to this recommendation that may be waived but that no school or person can require me to waive this right.

Mark one of the following statements:  I hereby WAIVE my right of access to this recommendation.

I do NOT waive my right of access to this recommendation.

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*APPLICANT SHOULD NOT WRITE BELOW THIS SPACE*

TO THE EVALUATOR: Please provide your candid evaluation of this applicant's ability to participate in the Summer Research Program and their motivation to attend graduate school and pursue a career in biomedical research. Use space on back of form if necessary.

In what capacity and how long have you have known the applicant? \_\_\_\_\_

On the following scale, please rate this applicant relative to other students whom you have known. \_\_\_\_\_

Top 2%	Top 10%	Top 25%	Top 50%	Bottom 50%	No basis for judgment
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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Title and  
 Department: \_\_\_\_\_ at \_\_\_\_\_  
 (College or University)

Address: \_\_\_\_\_ Signature: \_\_\_\_\_

Please return this form directly to: Director, Summer Research Program, Department of Biochemistry, 4301 W. Markham St., Slot 516, Little Rock, AR 72205-7199