St. Tammany Health System

Collegiate Shadowing PROGRAM PARTICIPANT
RECOMMENDATION
CONFIDENTIAL

Please obtain recommendations from an instructor, professor, counselor or employer. No family member recommendations accepted.

PRINT Name of Applicant: ____________________________________________

Please answer all questions. Please mark "NA" if the situation is not applicable. All comments will be kept strictly confidential.

1. Is the applicant prompt? _____Yes _____No _____NA

2. Does the applicant accept responsibility? _____Yes _____No _____NA
   Please explain: ____________________________________________________

3. Is the applicant a leader? _____Yes _____No _____NA
   In what areas? ___________________________________________________

4. Is the applicant courteous to others? _____Yes _____No _____NA

5. Is the applicant a diligent worker? _____Yes _____No _____NA

6. What is his/her quality of work? ____________________________________

7. How long have you known the applicant? __________________________

8. Would you recommend the applicant to participate in the Summer Volunteer Program at St. Tammany Parish Hospital? _____Yes _____No _____NA
   Please explain: ___________________________________________________

9. Any additional comments about why this applicant would be a good choice for the program. __________________________________________________________

PRINT INFORMATION CLEARLY:
NAME OF PERSON COMPLETING THIS FORM: __________________________
YOUR PHONE NUMBER: __________________________
HOW DO YOU KNOW THIS PERSON: __________________________
DATE: __________________________

PLEASE MAIL, EMAIL OR FAX THIS FORM DIRECTLY TO:
ST. TAMMANY HEALTH SYSTEM
ATTENTION: EDUCATION, DEVELOPMENT & TRAINING DEPARTMENT
1202 S. TYLER STREET
COVINGTON, LA 70433
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