

**Reference Form for Health Professions Bachelor of Science Degree Completion Option**

**To be completed by applicant:**

Name of applicant: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Other name(s) which may appear on records: \_\_\_\_\_

**RELEASE:** Under the Family Education Rights and Privacy Act, enrolled students have the right to inspect their files upon request. In order to inform the person you have requested to complete this reference form whether the form will be held in confidence or if the letter will be open to your inspection, please check one of the following statements. Waiving your rights to see this form is not a requirement for admission.

I do hereby waive my right to access this reference form.       I do not hereby waive my rights to access this form.

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

Please return by: \_\_\_\_\_

**To be completed by reference:**

Reference name: \_\_\_\_\_ Date: \_\_\_\_\_  
(please print)

Relationship to applicant: \_\_\_\_\_ How long have you known the applicant: \_\_\_\_\_

How well do you know the applicant?    Very well    Somewhat well    Not well

	Excellent	Good	Average	Below Average	No Basis for Judgment
1. Ability to work with people					
2. Leadership					
3. Integrity					
4. Self-direction					
5. Concern for others					
6. Accountability for professional practice					
7. Ability to use critical thinking skills					
8. Ability to incorporate standards of care into professional practice					
9. Ability to provide safe, competent care for others					

If rated below average, please comment:

\_\_\_\_\_

\_\_\_\_\_

Indicate any significant limitations for success in the Health Professions Bachelor of Science degree completion option:

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Special abilities for success in the program:

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Please indicate your level of endorsement for the suitability of the candidate for the program:

Endorse with enthusiasm     Endorse     Do not endorse

Please explain:

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

Position/Title: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Please send to:

**Bryan College of Health Sciences**

Attention: Admissions Office

5035 Everett St.

Lincoln, NE 68506-1398

bryanhealthcollege.edu

This reference is valid for one year after the date received.

