

**TO THE APPLICANT:** You must have two (2) completed recommendations from two (2) separate people who know you well. One must be filled out by someone from your school, and one must be filled out from someone outside of your school.

**TO THE RECOMMENDER:** Please answer the following questions. If you have any questions, please contact BHCS Medical Staff Office at rcenteno@browardhealth.org. Thank you for your assistance.

|                           |        |
|---------------------------|--------|
| Applicant Name:           |        |
| Reference Name:           |        |
| Organization/Institution: | Title: |
| Email:                    | Phone: |

On a scale of 1-5, with 1 being the lowest level of recommendation and 5 highest level of recommendation, how strongly would you recommend this student for the \$1500 Scholarship.

1     2     3     4     5

1. How long and in what capacity have you known the Applicant?



|  |       |
|--|-------|
| 2. What do you consider the Applicant's primary strengths to be?   |       |
| 3. Why do you feel the Applicant is a good candidate for the BHCS Medical Staff Scholarship?                             |       |
| 4. Please share any additional information you believe should be taken into consideration when reviewing this applicant. |       |
| 5. Reference Signature:  | Date: |