EVALUATION REQUEST

HEALTH PROFESSIONS COMMITTEE

____Medical School
____Dental School
____Optometry School
____Veterinary Medical School
____Allied Health School

I request that a personal and academic appraisal of my pre-professional coursework be formulated by the Samford University Health Professions Committee. My signature indicates that I willingly waive my right of access to all evaluations and correspondence.

My signature below further authorizes the Health Professions Committee to review my academic transcript, and to obtain personal and academic evaluations from the Samford University faculty members listed below: (*We advise you to choose five faculty: minimum two from A, two from B, and at least one from your major.)*

The information you provide should be accurate and readable since it will be used to contact the faculty members. If the faculty member is no longer at Samford University, a correct mailing address must be given.

A.

Biology:	_____	_____
	(Title, First Name, Last Name)	(Title, First Name, Last Name)
Chemistry:	_____	_____
	(Title, First Name, Last Name)	(Title, First Name, Last Name)
Math:	_____	_____
	(Title, First Name, Last Name)	(Title, First Name, Last Name)
Physics:	_____	_____
	(Title, First Name, Last Name)	(Title, First Name, Last Name)

B.

English:	_____	_____
	(Title, First Name, Last Name)	(Title, First Name, Last Name)
World Languages:	_____	_____
	(Title, First Name, Last Name)	(Title, First Name, Last Name)
Social Sciences:	_____	_____
	(Title, First Name, Last Name)	(Title, First Name, Last Name)
Other: (Specify)	_____	_____
_____	(Title, First Name, Last Name)	(Title, First Name, Last Name)

Name:_____ _____ _____
(First) *(Middle)* *(Last)*

SUid: 9 _____

Signature:_____ Date_____

Phone:_____ e-mail:_____

Return form to Darlene Dowdy, SCI 222, or SU Box 2234.

H:/PREMED/Pre-Med/evaluation request