

Department of Physical Therapy Pediatric Residency Program
2012-2013

Reference Report

Name of Applicant: _____

Authorization for waiver to be read and signed by the applicant: Agreeing to waive your right to review this waiver is not required as a condition for admission to the residency program.

I understand my right under the US Family Rights and Privacy Act of 1974 to review confidential appraisals placed in my file that are submitted with reference to admission to the Department of Physical Therapy Pediatric Residency Program.

I do () do not () waive my right to review this reference report

Signature of Applicant

Date

TO THE APPLICANT: Complete the above information and send this form to the individual who will be providing your reference. Reference reports should be sent directly by the evaluator to the Department of Physical Therapy at The Children's Hospital of Philadelphia. Once received, this reference is the property of the Department of Physical Therapy and will not be returned.

TO THE EVALUATOR: Complete the information request on all 3 pages. If you need to use additional space please add that to this form. Your comments will be completely confidential, if the applicant has waived his/her rights to access. Your candid completion of this form is appreciated. Please return to Sue Migliore PT, DPT, MS, PCS Clinical Practice Coordinator CSH Room 216 Mail Stop: CO2-1103, 3405 Civic Center Boulevard, Philadelphia, PA 19104, phone: 215-590-4411 fax 215-590-9162.

Migliore@email.chop.edu.

Name of evaluator: _____

Evaluator's Position or Title: _____

Evaluator's Employer: _____

Evaluator's Phone Number: _____

Evaluator's Email Address: _____

How long and in what capacity have you known this applicant?

In evaluating this applicant, what reference group are you using for comparison?

Keeping in mind your reference group, please evaluate the applicant as fairly as you can in each of the following categories, by placing an “X” in the appropriate box, with 1 being “poor” and 5 being “excellent”. Please feel free to make any additional comments in the space provided.

	1	2	3	4	5	N/A	Comments
Able to express ideas and feelings orally							
Ability to communicate in writing							
Skills in teaching and professional presentation							
Skills in making clinical decisions							
Ability to review the literature and articulate ideas around evidence-based practice							
Ability to accept constructive feedback							
Intellectual ability							
Leadership potential							
Motivation and commitment							
Teamwork							
Accountability							
Professionalism							
Ability to effectively interact with individuals of all ages, abilities, and cultural backgrounds							

We are especially interested in your comments regarding this applicant's aptitude for continued professional growth and potential to become an advanced practitioner in pediatric physical therapy:

What do you consider to be the applicant's major strengths?

In what area does the applicant need further development?

Summary Evaluation

_____ I **do not** recommend this applicant for the Department of Physical Therapy Pediatric Residency Program

_____ I believe this applicant's qualifications are **marginal**.

_____ I **recommend** this applicant for the residency and believe his/her performance should be comparable to most professionals with similar experience

_____ I **strongly recommend** this applicant for the residency and believe that s/he has the capability to perform at a superior level.

Signature of Evaluator

Date