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. PLEASE CHECK WITH FACULTY MEMBERS BEFORE PUTTING THEIR NAMES ON THIS FORM.

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 Cindy Kennington, SCI 222, or SU Box 2234.