MercyOne Centerville (Auxiliary/Foundation) Scholarship
References 2027

Date: _____Name of applicant:_____
Your Relationship to Applicant:_____
(Non-relative)

Please complete this reference form with your recommendation and **mail/fax/ by April 2** to:

Barbara Brown
MercyOne Centerville Medical Center
1 St. Joseph Drive
Centerville, IA 52544
Fax: 641-548-5203
Email: barbara.brown004@mercyoneiowa.org

Please rate the applicant's achievement and potential by entering an "X" in the appropriate spaces below.

| Skill | Exceptional | Above Average | Average | Below Average | No Response |
|---|---|---|---|---|---|
| Decision-making ability | | | | | |
| Organizational Skills | | | | | |
| Communication skills:<br>• Written<br>• Oral | | | | | |
| Adaptability to stress | | | | | |
| Positive Attitude | | | | | |
| Integrity | | | | | |
| Interpersonal Sensitivity | | | | | |
| Leadership ability | | | | | |
| Ability to commit to:<br>• Goals<br>• Persons | | | | | |

In addition to the ratings, please give your evaluation of the applicant. It is important that you complete this section. You may want to indicate your perceptions of the applicant's strengths and limitations.

My recommendation is: ○ highly recommend ○ recommend ○ do not recommend

| | |
|---|---|
| Signature of Person Making Recommendation | Date |
| Printed Name | Business and Position (if applicable) |
| Address | |
| Primary Phone Number | Secondary Phone Number |