

## CONFIDENTIAL RECOMMENDATION REPORT

### ADVANCED CLINICAL TRAINING OR PRECEPTORSHIP APPLICATION

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Name of applicant: \_\_\_\_\_  
(Last) (First)

Name of program: \_\_\_\_\_

How long have you known this applicant: \_\_\_\_\_

What is your relationship to this applicant: \_\_\_\_\_

*The applicant has waived the right to access this evaluation.*

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Please evaluate the applicant in the following categories:

ATTRIBUTE	EXCEEDS EXPECTATION	MEETS EXPECTATION	DOES NOT MEET EXPECTATION	COMMENTS: (REQUIRED FOR EXCEEDS OR DOES NOT MEET EXPECTATION RATING)
Critical Thinking				
Didactic Knowledge				
Clinical Skills				
Interpersonal Skills and Communication				
Integrity and Ethics				
Maturity				
Organizational Skills				
Professional Demeanor				
Reaction to Criticism				
Self-Awareness				
Motivation				

Additional remarks:

**OVERALL, I WOULD:**

RECOMMEND WITHOUT RESERVATION	HIGHLY RECOMMEND	RECOMMEND	NOT RECOMMEND

**Evaluator contact information:**

Name of evaluator: \_\_\_\_\_ Date of form completion: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
(name of institution/practice)

email address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Telephone number: \_\_\_\_\_

Evaluator signature: \_\_\_\_\_

*Please complete the form and submit electronically to: Postgraduate Programs Officer at [postdds@dentistry.ucla.edu](mailto:postdds@dentistry.ucla.edu)*