

## APPLICANT SUPPORT FORM

**Confidential – Do not return to the Applicant**

<b>A – TO BE COMPLETED BY THE APPLICANT</b>	
Name (last name, first name)	CaRMS file no.
Date	Signature

<b>B – TO BE COMPLETED BY THE REFEREE</b>
---

I have known this Applicant for \_\_\_\_\_ years and/or \_\_\_\_\_ months.  
 At the time, the Applicant was \_\_\_\_\_ (please specify, e.g. "a student")  
 My relationship to the Applicant: \_\_\_\_\_

Please evaluate the Applicant by checking the appropriate box. Applicant should be evaluated in comparison to other students of similar level, experience and training that you have known over the course of your career.

	Inadequate	Below average	Average	Above average
1. <b>Communication skills:</b> expresses thoughts clearly; speaks concisely and coherently				
2. <b>Interpersonal skills:</b> respects others; is a good team player; is patient and open-minded				
3. <b>Maturity level:</b> shows good judgement; reasons logically; has integrity; is responsible and disciplined; is involved with the community; is independent; is capable of self-criticism; is able to make difficult decisions				
4. <b>Motivation:</b> is persevering and determined; does more than the minimum required; is able to impose his/her own ideas while respecting those of others				
5. <b>Curiosity:</b> checks knowledge at the source; has continuous improvement approach to learning; shows interest in research; has good observation skills				
6. <b>Clinical skills:</b> is easily accepted by patients; is able to define problems clearly; shows good clinical judgement; makes efficient use of diagnostic services; is able to justify his/her therapeutic interventions				

**Additional comments, if needed:**

---



---



---



---

**RECOMMENDATIONS:**

a) I recommend this Applicant       without reserve       with reserve       I would not recommend this Applicant

b) Please place an X on the line below to indicate your overall evaluation of this Applicant:

Exceptionally weak | \_\_\_\_\_ | Exceptionally strong

Date: \_\_\_\_\_      Name: \_\_\_\_\_

Signature: \_\_\_\_\_      Hospital: \_\_\_\_\_

**N.B. This document is confidential and must be returned to CaRMS with a cover page, which you must prepare and give to your Referee.**