



# Undergraduate Pharmacology Program

Dept of Pharmacology, BST-8 Rm. 140, Stony Brook University, Stony Brook, NY 11794-8651

## LETTER OF RECOMMENDATION

**TO BE COMPLETED BY THE STUDENT:**

Name of Applicant: _____ <small style="display: flex; justify-content: space-between; width: 90%; margin-left: 20px;"> <span>Last of Family Name</span> <span>First Name</span> <span>Middle Name</span> </small>	Social Security Number _____
Current Address: _____	Semester and Year Applying for: _____
City, State: _____	Telephone: _____
Zip Code, Country: _____	
I understand that I have the right to inspect my file upon request under the Family Educational Rights and Privacy Act of 1974. I hereby DO WAIVE my right of access to this letter of recommendation.	
_____ <i>Signature of Student</i>	_____ <i>Date</i>

**TO BE COMPLETED BY THE RESPONDENT:**

Respondents are requested to write a statement on this form and mail it in a sealed envelope to the address above. If additional space is needed, please attach a separate page. The Undergraduate Pharmacology Program is grateful for any pertinent information regarding the applicant, but will particularly appreciate the writer's opinion of the candidate's ability to carry on advanced studies. A careful discrimination between strong and weak characteristics of the candidate will be more helpful than routine praise.

	Upper 1% or 2%	Upper 10% but not upper 1% or 2%	Upper 25% but not upper 10%	Upper half but not upper 25%	Lower half	No basis for judgment
Academic Performance						
Intellectual Ability						
Ability to Express Him/Herself						
Motivation for Pharmacology						

**Overall assessment of the student:**

Least qualified  
 Recommended  
 Highly recommended  
 Outstanding  
 Unable to answer

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_ Position \_\_\_\_\_

Address \_\_\_\_\_