



**Riverside Physical Therapy Spine Rehab Fellowship Program**

**RECOMMENDATION FORM**

Name of Applicant:

Individual(s) providing recommendation(s):

Name/Credentials:

Current Position:

Mailing Address:

Phone Number:

Email Address:

Are you willing to discuss this Applicant's qualification over the phone with a member of the selection committee? (Circle the appropriate response). Yes No

Relation of Individual providing recommendation to Applicant (Circle the appropriate response):

Clinical Supervisor

Employer

Academic Instructor

Professional Colleague

Other (please specify):

Number of years known Applicant (Circle the appropriate response):

Less than 2

2 to 5

Greater than 5

Compared to other Applicants that you would recommend to this fellowship program, the Applicant would rank in the (Circle the appropriate response):

Top 1%

Top 5%

Top 10%

Top 25%

Top 50%

What is the most valuable quality or characteristic that the Applicant possesses?

Provide a brief example or description illustrating your observation of the Applicant's use of that quality or characteristic.

Please feel free to attach other information pertinent to the applicant's recommendation.

**(Thank you for taking the time to recommend this Applicant to our fellowship program)**

**Riverside Physical Therapy Spine Rehab Fellowship Program - continued**