RECOMMENDATION FORM FOR COLLEGIATE SCHOOL OF MEDICINE AND BIOSCIENCE (CSMB)

PLEASE COMPLETE, SIGN AND RETURN THIS FORM TO:

Frederick Steele
1547 S. Theresa Ave
St. Louis, MO 63104
Fax: 314-244-1790
Email: claudia.walley@slps.org

IF NECESSARY, PLEASE USE THE REVERSE SIDE FOR ADDITIONAL COMMENTS.

STUDENT'S NAME: ____

SCHOOL: ____

____ I DO RECOMMEND THIS STUDENT FOR CSMB

____ I DO NOT RECOMMEND THIS STUDENT FOR CSMB

PLEASE CHECK THE APPROPRIATE RATING

	EXCELLENT	GOOD	NEEDS IMPROVEMENT	POOR
Academic Performance	________ (A – B+)	________ (B-C)	________	________
Assuming Responsibility	________	________	________	________
Attendance	________	________	________	________
Relationship with Peers	________	________	________	________

____
Name of Person Completing Form

____
Signature of Person Completing Form

____
Principal's Signature

____
Date and Telephone Number