WVNCC RADIOGRAPHY PROGRAM REFERENCE FORM

NAME OF APPLICANT_____
REFERENCE'S NAME_____
ADDRESS_____
CITY, STATE, ZIP_____
PHONE NUMBER (_____) _____
WHAT IS YOUR ASSOCIATION WITH THE APPLICANT? _____
HOW LONG HAVE YOU KNOWN THE APPLICANT? _____

The above named person has applied for admission to the WVNCC Radiography Program. Please complete and return this form to the "WVNCC Admissions Office, 1704 Market Street, Wheeling, WV 26003".
ALL INFORMATION WILL BE HELD CONFIDENTIAL.

*Please score the following categories from 5 to 1, with **5** being "Exceptional" and **1** being "Poor". Any score of **2** or lower REQUIRES a comment.

Attendance	5	4	3	2	1	Comment:
Reliability (completes tasks in a timely manner)	5	4	3	2	1	Comment:
Initiative	5	4	3	2	1	Comment:
Quality of Work	5	4	3	2	1	Comment:
Compliance of Rules & Policies	5	4	3	2	1	Comment:
Maturity	5	4	3	2	1	Comment:
Dependability (works as instructed)	5	4	3	2	1	Comment:
Willingness to cooperate & carry out instructions	5	4	3	2	1	Comment:
Ability to learn & meet changes	5	4	3	2	1	Comment:
Trustworthiness	5	4	3	2	1	Comment:
Rate your opinion of the applicant's success in the health care field.	5	4	3	2	1	Comment:

Additional Comments:_____
_____
_____

DATE_____ SIGNATURE/TITLE_____

I hereby authorize the WVNCC Radiography Program to make a thorough investigation of my references and all the facts stated on my application for admission. I release from all liability or responsibility all persons, places of business and municipalities supplying such information.

DATE_____ APPLICANT_____

(Reviewed 3/19 ~ MDK, MJS)