

Capital Health System School of Nursing/
Mercer County Community College Cooperative Program
446 Bellevue Avenue
Trenton, New Jersey 08618

Reference

Name of Applicant _____
Last (Print) First Middle Maiden

Address _____

Social Security # _____

The above named applicant has applied for admission to the Capital Health System School of Nursing, and has submitted your name as a reference. We would appreciate you using this form to record your perceptions of the applicant's performance and potential. Your cooperation in completing and promptly returning this form will assist both the School of Nursing and the applicant.

In accordance with the Family Education Rights and Privacy Act, a student admitted into this School of Nursing has the right to inspect this reference, unless the student has signed a waiver of this right of access (see waiver below). Capital Health System School of Nursing does not require a waiver as a condition for admission to, receipt of financial aid form or receipt of any other services or benefits from the school. Applicants submitting names of individuals as references are free to decide if they wish to waive their right to examine references.

WAIVER

The Family Educational Rights and Privacy Act permits us to request, but not require, that you waive your right to inspect this evaluation. The right, which we request that you waive, would arise if you were an enrolled student at this school and if the evaluation were maintained after your enrollment. In considering whether you will waive, please be advised that the information contained on this form will be used to evaluate you as an applicant for admission to this School of Nursing. If you elect to waive your rights of access to and review of this information, please sign your name.

(Date) (Applicant's Signature)

Please sign the following release:

I hereby authorize _____ to supply information concerning me for reference to Capital Health System School of Nursing.

(Date) (Applicant's Signature)

Applicants to the Capital Health System School of Nursing/Mercer County Community College Cooperative Program are selected in accordance with nondiscriminatory practices.

1. How long have you known this applicant and in what capacity?

2. Do you consider this applicant a good registered nurse candidate?
Please identify strengths and weaknesses.

3. Please check the following:

	Excellent	Good	Fair	Poor	Info Not Available
Work Performance					
Ability					
Reliability					
Cooperativeness					
Accountability					
Leadership Ability					
Involvement in community and/or school activities					

4. Additional comments:

(If waiver has been signed on reverse side of this form, be assured that your reference will not be reviewed by applicant).

(Date)

(Signature)

(Position)

(Place of Employment)

(Address)

Please return this form directly to Registrar of Capital Health System School of Nursing/Mercer County Community College Cooperative Program.