

**Applicant Reference Form**

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**University of Texas Southwestern Medical Center  
Department of Physician Assistant Studies  
Parkland Health & Hospital System  
Physician Assistant Residency Program in Trauma & Burns**

Applicant: Please complete the top portion of the form and sign the following waiver of confidentiality. Provide a standard business-sized envelope to the evaluator.

Applicant's Name: \_\_\_\_\_  
Last First Middle

Applicant's Social Security Number: \_\_\_\_\_

Applicant's Mailing Address: \_\_\_\_\_

**Applicant's Waiver of Right of Access to Confidential Statement:**

I hereby voluntarily waive my right of access to any information contained on this reference form and agree that the statements shall remain confidential.

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

Evaluator: Because of federal legislation giving students access to educational records, the Physician Assistant Residency Program cannot guarantee the confidentiality of your statement unless the applicant has signed the Waiver printed above.

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**To the person completing the reference form:** The Department of Physician Assistant Studies at the University of Texas Southwestern Medical Center and Parkland Health & Hospital Systems greatly Appreciate your completion of this form. Please seal the completed reference form in the envelope provided by the applicant and sign your name across the back seal. The sealed envelope should be returned directly to the applicant.

**How long have you known the applicant?** \_\_\_\_\_

**What is the nature of your relationship with the applicant?** \_\_\_\_\_

Please comment upon the strengths and weaknesses of the applicant according to your knowledge of him/her in the following areas:

**Maturity:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Initiative/Motivation:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Work Ethic:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Ability to Work with Others:** \_\_\_\_\_

\_\_\_\_\_

**Flexibility:** \_\_\_\_\_

\_\_\_\_\_

**Ability to Problem Solve:** \_\_\_\_\_

\_\_\_\_\_

**Professionalism:** \_\_\_\_\_

\_\_\_\_\_

**Have you observed the applicant's interactions with patients?**       Yes     No

If yes, please comment on the applicant's interaction style:

\_\_\_\_\_

\_\_\_\_\_

**Additional comments:** \_\_\_\_\_

\_\_\_\_\_

**May we contact you by telephone for additional information?**       Yes     No

- Recommendation** (check one):
- The applicant has my highest recommendation.
  - I recommend the applicant with confidence.
  - I recommend the applicant with some reservation.
  - I do not recommend the applicant.

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

Name (printed or typed): \_\_\_\_\_ Title/Dept. \_\_\_\_\_

Institution: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

**Upon completion, please seal this form in the envelope provided by the applicant and sign your name across the seal. Return the sealed envelope directly to the applicant. The applicant will submit all materials in one envelope to the residency program. All application materials must be received by June 30 for fall admissions and November 30 for spring admissions for the applicant to be considered.**