

**The University of Western Ontario
Schulich Medicine & Dentistry
Combined MD/PhD Program**

Confidential Assessment

To the Candidate:

1. RECORD YOUR NAME AND ADDRESS IN THE SPACE ON THE RIGHT
2. SIGN THE FORM AND FORWARD IT TO THE REFEREE

Referee Name	Candidate's Name
Signature	Signature
Title	Candidate's Address
Address	Postal Code
Postal Code	Phone Number
Phone Number	

To the Referee:

1. TYPE OR PRINT LEGIBLY IN BLACK, USE ONE ADDITIONAL PAGE IF NECESSARY
2. CHECK EACH ITEM IN THE GRID BELOW IN THE BOX WHICH BEST INDICATES YOUR RATING OF THE CANDIDATE AS COMPARED TO HIS OR HER PEERS. INCLUDE ANY ADDITIONAL RELEVANT INFORMATION IN THE COMMENTS AREA OR ON AN ATTACHED PAGE
3. PRINT YOUR NAME AND ADDRESS IN THE SPACE ABOVE AND FORWARD THE FORM DIRECTLY TO MD/PHD ADMISSIONS, CARE OF VICKI VANSTRIEN, ROBARTS RESEARCH INSTITUTE, SUITE 1240, THE UNIVERSITY OF WESTERN ONTARIO, N6A 5K8
4. ***PLEASE NOTE: THIS FORM MUST BE RECEIVED BY DECEMBER 1ST**

	EXCELLENT	VERY GOOD	GOOD	AVERAGE OR BELOW	NOT ABLE TO ASSESS
PRESENT ABILITY AT RESEARCH					
RESEARCH POTENTIAL					
INTELLECTUAL CAPACITY					
ORIGINALITY					
INITIATIVE					
JUDGEMENT/INTEGRITY					
MATURITY					
EMOTIONAL STABILITY					
ORAL AND WRITTEN SKILLS					
ABILITY FOR SELF-DIRECTED LEARNING					

I HAVE KNOWN THE APPLICANT FOR _____ YEARS
 IN MY CAPACITY AS

Please elaborate on the assessment given in the table using the space below (attach a separate sheet if necessary). Other relevant comments may be added. Please type or print clearly.

REFEREE'S SIGNATURE _____ DATE _____