Western University
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's Name and Title	Candidate's Name
Referee's Signature	Candidate's Signature
Referee's Address	Candidate's Address
Referee's Phone Number	Candidate's 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 STACEY BASTIEN, CLINICAL SKILLS BUILDING, ROOM 2720, RESEARCH OFFICE, SCHULICH SCHOOL OF MEDICINE AND DENTISTRY, WESTERN UNIVERSITY, LONDON, ONTARIO, N6A 5C1
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_____