



**UT COLLEGE OF PHARMACY / UTMC  
PHARMACY PRACTICE (PGY1) RESIDENCY  
APPLICATION**

**REQUEST FOR RECOMMENDATION**

**To be completed by the applicant**

Name of Applicant:  
(Please print or type)

First Name	MI	Last Name
Street Address or P.O. Box		
City	State	Zip
( ) -		
Telephone		

I waive the right to review this recommendation.

\_\_\_\_\_  
Signature of Residency Applicant

**To be completed by individual completing the recommendation**

Applicants to our residency program are required to have letters of recommendation submitted by persons who are in a position to evaluate their qualifications for residency training. The individual completing the recommendation is asked to make an honest appraisal of the applicant's character, personality, abilities, and suitability for a pharmacy residency. All comments and information provided will be kept in strict confidence as allowed by Ohio Law. In your letter of recommendation, please address each of the following:

- How long you have known the applicant and in what capacity?
- What are the applicant's strengths and weaknesses?
- How would you rate the applicant's time management skills?
- How is the applicant able to deal with difficult personalities and situations?
- How is the applicant motivated to perform at a high level in stressful situations?
- What is your recommendation on the applicant's candidacy?

\_\_\_\_\_  
Signature of individual completing the recommendation

\_\_\_\_\_  
Typed or printed name and title

\_\_\_\_\_  
Institution/Company

\_\_\_\_\_  
Address or P.O. Box

City	State	Zip
( ) -	( ) -	
Telephone	Fax	

The letter of recommendation should be mailed or faxed to:

Chad Tuckerman, Pharm.D.  
University of Toledo Medical Center  
Department of Pharmacy Services  
3000 Arlington Avenue  
Toledo, OH 43614  
Fax (419) 383-3032