

THE OHIO STATE UNIVERSITY
SCHOOL OF ALLIED MEDICAL PROFESSIONS
RECOMMENDATION FORM

Applicant _____ Soc. Sec. # _____

Division/Program _____ Qtr./Yr. of Graduation _____

Waiver of Right of Access to Letter of Recommendation: The Family Educational Rights and Privacy Act of 1974, P.L. 93-380, allows a candidate for admission, employment, or receipt of honors to waive his or her right of access to confidential letters or statements written on his or her behalf if the recommendation is used solely for the purposes of admission, employment, or the receipt of honors and, if the candidate, upon request, is notified of the names of all persons making such recommendations on his or her behalf. The University cannot require persons to sign waivers as a condition for using Career Services.

I hereby waive my right of access to this recommendation and appropriate attachments written by (name of recommender) _____ on behalf of my application for admission, employment, or receipt of honors. This waiver is effective only insofar as the recommendation is used solely for the purposes stated above. **[Sign below ONLY if waiving your right of access.]**

Signature

Date

TO RECOMMENDER: **Reference Letter** (Type if possible; attach additional sheets as necessary, or complete separately and attached to this form.)

Signature of person writing reference _____ Date _____

Type or print name above _____

Occupation/Title _____ Employer _____