COLLEGE OF NURSING AND ALLIED HEALTH
DEPARTMENT OF REHABILITATION AND DISABILITY STUDIES
CLINICAL REHABILITATION COUNSELING

SOUTHERN UNIVERSITY
BATON ROUGE, LOUISIANA 70813

LETTER OF RECOMMENDATION

Applicant's Name_____

Name of the person completing this form_____

Under the Federal Family Education Rights and Privacy Act of 1974, students are entitled access to their records including letters of recommendation. However, those writing recommendations and those reviewing recommendations may attach more significance to them if it is known that the information will remain confidential. It is your option to waive your rights to access to these recommendations or to decline to do so. Please place a check on the appropriate line below indicating your choice and sign your name.

☐ I waive my right to review this recommendation.

☐ I do not waive my right to review this recommendation.

_____ _____

Signature of Applicant Date

This applicant whose name appears above has applied for admission to the Master's Degree Program in Clinical Rehabilitation Counseling and has given your name as a reference. We would appreciate your objective evaluation based on your knowledge of the candidate's ability to pursue graduate studies in Clinical Rehabilitation Counseling. It would be most helpful if you would address the following issues in your comments:

A. length of time and the capacity in which you have known the applicant;
B. your perception of the applicant's academic ability, motivation, strength, and weakness;
C. practical experience in rehabilitation and/or related fields;
D. oral, written, research, social, and teaching skills;
E. potential to be a good Clinical Rehabilitation Counselor; and
F. overall recommendation.

PLEASE PROVIDE YOUR RECOMMENDATIONS ON OFFICIAL LETTERHEAD

AND RETURN TO: *Madan M. Kundu, Ph.D., FNRCA, CRC, NCC, LRC*
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