

Applicant Name: _____

2. Do you Highly Recommend Not Recommend

3. How long have you known applicant? _____

4. In what capacity have you known Applicant? _____

Name of person completing form (**Type or Print**): _____

Signature: _____ Date: _____

Title: _____

Place of Employment: _____

Address: _____

City/State/Zipcode: _____

Phone: _____ Email: _____

5. Additional Information: Please list any additional information that may assist in the evaluation of the applicant for admission or submit a separate document.

PLEASE MAIL TO: Department of Health Information Administration
College of Health Sciences
Chicago State University
BHS 427
9501 South King Drive
Chicago, Illinois 60628—1598
773.995.2593

PLEASE SIGN ACROSS ENVELOPE FLAP – THANK YOU.