ARMSTRONG ATLANTIC STATE UNIVERSITY

Department of Communication Sciences & Disorders
11935 Abercorn Street | Savannah GA 31419
912.344.2969 | Fax 912.344.3439
armstrong.edu

To the Applicant:

1. Complete the information in this section reading the waiver options carefully. Be aware that some individuals will complete a reference only if you have waived the right of access.
2. Select 3 people who are familiar with your academic or professional performance to complete a copy of this form and return it to you in a **sealed, signed envelope**. The form must be included in your application packet.
3. **Both pages must be returned in order for your application packet to be considered.**

Applicant Name: ____
(Please type or print) Last *First* *Middle/Maiden*

Date of Birth: ___/___/___ For Class Beginning: **FALL** ______ 907#:________________________

Under provisions of the Family Education Rights and Privacy Act of 1974, you have the right to access the contents of this reference form once enrolled as a student at this college. You also have the option of waiving this right. Please indicate your preference by selecting one of the options, signing and dating this form.

____ **I** WAIVE my right to access the contents of this reference form and authorize my reference to provide Armstrong Atlantic State University with information that may be required in support of my application.

____ **I** do NOT waive my right to access the contents of this recommendation form, but **I** authorize my reference and his/her institution to provide Armstrong Atlantic State University with information that may be required in support of my application.

Signature of Applicant: ___________________________________ Date: __________

To the Referee:

This applicant seeks admission in our Master of Science in Communication Sciences and Disorders Program. The information you provide will be used to supplement the applicant's academic record and will aid us in the selection process. **Please return this form in a sealed, signed envelope to the applicant**. Your candid assessment is appreciated and is required to complete the application process. Please mail the completed reference from to:

Referee Name: ____
(*Please type or print) Last* *First* *Middle/Maiden*

Mailing Address: ____

Job Title: __________________________________ Telephone: ______________________________

1. Approximately how long have you known this applicant? ______ YEARS _____ MONTHS
2. How well do you feel you know the applicant? □ Casually □ Well □ Very Well
3. In what capacity? □ as my advisee □ research assistant
□ as a student in an online class □ as a student in a large lecture course
□ as a student in a small class □ as a student in laboratory courses
□ as a student engaged in research or independent study under my direction
□ as an employee (describe)____
□ other (please describe):____

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Applicant Name: ____

4. Please rate the applicant using the following scale in comparison to other students or employees whom you have known in a similar capacity. Please place an "X" in the appropriate column.

Characteristics	**Top 2%**	**Top 10%**	**Top 25%**	**Top 50%**	**Lower 50%**	**Not able to judge**
Emotional Maturity/Stability						
Social Maturity						
Attendance and Punctuality						
Oral Communication Skills						
Written Communication Skills						
Dependability/Responsibility						
Interpersonal Skills						
Respect for Others						
Academic performance						
Ability to apply theory to clinical practice						
Potential success as a clinician						
Initiative, self-reliance						
Ability to accept and benefit from constructive criticism						
Proficiency and experience in working with groups						

5. Recommend for Graduate Study? □ Strongly recommend □ Recommend □ Recommend with reservations □ do not recommend

6. Additional Comments:

Signature of Referee: ______________________________________ Date: ___________

Please include the completed Reference Form in the admissions packet and mail to:
Graduate Enrollment Services
Armstrong Atlantic State University
Victor Hall, Second Floor
11935 Abercorn Street
Savannah, Georgia 31419
Phone: (912) 344-2798 Fax: (912) 344-3488