Syracuse University

College of Arts & Sciences
Advising and Career Services

Health Professions Advising Request for Letter of Recommendation

Name (*Please Print*)_____ SUID _____

Applying to (check one): ◯ Medical School ◯ Dental School Email_____

Letters from Recommenders MUST be *received* by May 1st of your application cycle year.

Please complete this form as soon as possible to give your recommender enough time to complete their recommendation by the deadline above. Recommenders will be sent an email by our office requesting that they submit their recommendation for the health profession indicated on your Intent to Apply.

I am requesting a **Letter of Recommendation** from:

Name and Title of Recommender
Campus/Office Address
Email Address

My relationship with the Recommender is:

☐Professor/Science ☐Professor/Major ☐Professor/Other

☐Research/Internship ☐Clinical Experience ☐Community Service ☐Employment ☐Leadership

Other _____

I have known the Recommender since (indicate date(s)/course(s)): _____

Current federal law provides that applicants may have access to material such as individual recommendations. Applicants may choose, however, to waive this statutory right. For further information you may inquire with the Office of Advising and Career Services.

Select one:

◯ I **do** waive my right of access to the individual letters of recommendation.

◯ I **do not** waive my right of access to the individual letters of recommendation.

Signature* _____ Date _____

**In typing your name in the Signature area, you are virtually signing the above document.*

You are responsible for supplying accurate and complete information, checking with our office to make sure recommendations have been received, and following up on recommenders who need a *gentle* reminder.

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