D.O. Evaluation

NOTE: The Family Education Rights and Privacy Act of 1974 provides a student access to his/her educational record. The student retains the right to waive access to specific documents in his/her record.

I do waive my right to access this document and associated supplemental information submitted by person(s) signed below.
I do not waive my right to access this document and associated supplemental information submitted by person(s) signed below.

Signature of Applicant: ____________________________ Date: ____________

Full Legal Name (please print):
Last: ______________ First: ________________ Middle: ______________ Maiden: ______________

<table>
<thead>
<tr>
<th>Variables for Consideration</th>
<th>Comments</th>
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<tr>
<td>Personal interest and activities.</td>
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<td>Leadership and community involvement.</td>
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<td>Motivation toward health care delivery and/or helping people.</td>
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<td>Depth of interest and knowledge of the osteopathic profession and its needs. (GP/specialist, academic, rural/urban)</td>
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<td>Realistic concept of academic, financial and personal demands of the program.</td>
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<td>Demonstrated ability to cope with stress.</td>
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<td>Reliability, resourcefulness and judgment.</td>
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<td>Communications skills.</td>
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Overall Impression of Applicant's Characteristics:
(Please assign 1-100 points using range below) ________________

100-90 = Outstanding  79-70 = Average  59-1 = Not Acceptable
89-80 = Above Average  69-70 = Below Average

After a Thorough Interview with Applicant, She/He is: (please select only one)

(4) Highly Acceptable  (3) Acceptable  (2) Conditionally Acceptable  (1) Not Acceptable

If (1), please give an explanation and state what applicant should do to achieve this goal.
____________________________________________________________________________________
____________________________________________________________________________________

If (2), please state condition of acceptance.
____________________________________________________________________________________
____________________________________________________________________________________

Please Print Name: ____________________________________________
Address: ____________________________________________________
Phone Number: ________________________________________________

Interviewer Signature: _________________________________________  Date: ___________________

If you have a business card, please attach it to this form.

This form may be faxed to OSU by the recommender at 918-561-8243 (to be followed by an original copy in the mail.)

Please mail directly to:
Oklahoma State University Center for Health Sciences
College of Osteopathic Medicine
Office of Student Affairs
1111 W. 17th St.
Tulsa, OK  74107-1898