

**YALE UNIVERSITY SCHOOL OF MEDICINE
DEPARTMENT OF ORTHOPAEDICS AND REHABILITATION**

To those writing letters of recommendation, please take an extra minute to fill out this form. We are fortunate to have many outstanding applicants, and completion of this form will be of great assistance to our residency selection committee. Please fax this to us at your earliest convenience, and thank you for your time.

Send this form to:

Yale University School of Medicine
Department of Orthopaedics and Rehabilitation
Attn: Kathy Umlauf
P.O. Box 208071
New Haven, CT 06520-8071

➔ **VIA FAX: 203-785-7132**

Applicant Name _____

Medical School, Class Year _____

	Poor	Average	Above Average	Very Good (Top 25%)	Excellent (Top 15%)	Outstanding (Top 5%)	Best This Year	Best Several Years
INTELLIGENCE								
FUND OF KNOWLEDGE								
INQUISITIVE NATURE								
WILLINGNESS TO WORK								
ABILITY TO WORK WITH OTHERS								
OVERALL								

Is the applicant a candidate for your program? Yes _____ No _____

Referee Name: _____

Address _____

Date: _____