

Section II: DC HPLRP Recommendation Form *(This is the second part of three sections that make up the DC HPLRP Application)*

Recommendation forms must be completed by professional references; at least two references must be the applicant's current or former supervisors.

Part A: Applicant Information *(to be completed by applicant)*

First Name: _____ MI: ____ Last Name: _____
Email: _____

Part B: Recommender Information *(to be completed by recommender)*

The individual listed above is applying to the DC Health Professional Loan Repayment Program (HPLRP). This form is confidential and will not be released to the applicant.

Recommender Name: _____
Title: _____
Address: _____
Telephone: _____

1. In what capacity do you know the applicant?
Current supervisor ____ Former supervisor ____ Professor ____ Other _____
2. How long have you known the applicant (approximate)? ____ Years ____ Months
3. What are the applicant's greatest strengths? _____

4. Can you identify any characteristics of the applicant that might limit their ability to provide 40 hours per week of clinical care for a minimum of two years? _____

DC Department of Health
Primary Care Bureau
899 North Capitol Street NE, 3rd Floor
Washington, DC 20002
(202) 442-9168 EMAIL: HPLRP@dc.gov



5. Please rate the applicant relative to other individuals you have known in the same capacity by checking the appropriate number on the rating scales corresponding to each characteristic below (1 = lowest; 5 = highest):

A. Demonstrates and understands the need to provide care to the underserved

1__ 2__ 3__ 4__ 5__

B. Demonstrates knowledge and acceptance of cultural diversity

1__ 2__ 3__ 4__ 5__

C. Possesses strong interpersonal skills

1__ 2__ 3__ 4__ 5__

D. Understands the health care delivery system

1__ 2__ 3__ 4__ 5__

E. Exercises maturity in relating to patients and in making decisions

1__ 2__ 3__ 4__ 5__

F. Ability to adapt and/or be flexible when relating to others on a professional basis

1__ 2__ 3__ 4__ 5__

Explain why you gave a score of 3 or less on any characteristics: _____

Recommender's Signature: _____ Date: _____

Thank you for completing this form.

SUBMIT FORM TO: HPLRP@dc.gov

Or mail to:

DC Department of Health
Primary Care Bureau
899 North Capitol Street NE, 3rd Floor
Washington, DC 20002
Telephone: (202) 442-9168