



**DOCTOR OF PHARMACY PROGRAM
APPLICANT EVALUATION FORM**

TO THE APPLICANT: Complete the top portion of this form and submit it to the person who can best evaluate your potential to pursue the Doctor of Pharmacy degree.

Applicant Name: _____

Applicant Address: _____

Evaluator's Name: _____ Title: _____

Address: _____

Affiliation: _____

Signing of the following waiver is optional.

Under the provisions of the Family Educational Rights and Privacy Act of 1974 as amended (P.L. 93-380), this applicant (if admitted and enrolled) will have access to the information provided on this form unless he/she has waived such access.

I hereby waive my right to review this evaluation form.

Signature of Applicant

Date

To the Evaluator: Please return this evaluation form to the applicant in a sealed envelope with your signature validating the closure so that it can be submitted with other documents. Your candid comments and evaluation of the above referenced applicant to the Doctor of Pharmacy Degree Program will assist us with the admission decision.

Non-Discrimination Policy: The University of Cincinnati reaffirms its policy that discrimination on the basis of race, color, religion, national origin, sex, sex orientation, physical or mental handicap, disabled veteran or veteran of the Vietnam Era, or age will not be practiced in any of its activities. In keeping with this policy you are strongly discouraged from referring directly or indirectly to an applicant's handicap.

