Cedars-Sinai Medical Center
**GRADUATE PROGRAM IN BIOMEDICAL SCIENCE AND TRANSLATIONAL MEDICINE**
8700 Beverly Boulevard
Atrium Building, 2nd Floor
Los Angeles, CA 90048

Email: gradprogram@csmc.edu
Web: http://research.csmc.edu/acad/gradprogram
Phone: (310) 423-8294

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**APPLICATION FOR ADMISSION**
LETTER OF RECOMMENDATION

**APPLICANT STATEMENT:** To be completed by the applicant. Failure to acknowledge the waiver in the box below will result in this letter becoming ineligible for consideration in the application for admission to the graduate program.

Name _____
Last/Family Name First/Given Name Middle Name (if any)

Address _____
Street City State/Province Postal Code Country (if not USA)

_____
Phone Number Email Address

☐ I understand that this letter of recommendation is to be received and maintained by the Cedars-Sinai Medical Center Graduate Program in Biomedical Science and Translational Medicine and hereby expressly waive any and all rights I might have of access to this letter under the Family Education Rights and Privacy Act of 1974, the California Information Practices Act of 1977 and any or all other laws, regulations or policies. This waiving includes, but is not limited to, the right to inspect the contents of this letter, the right to make a copy of this letter for my use and the right to change or make amendments to this letter.

**APPLICANT MUST COMPLETE THIS PART**
**RECOMMENDER MUST COMPLETE THIS PART**

**APPLICANT EVALUATION:** Please complete the evaluation form below **in addition** to a signed letter of recommendation printed on paper with your institution's letterhead.

| | Outstanding | Excellent | Very Good | Average | Cannot Assess |
|---|---|---|---|---|---|
| Intellectual Ability | ☐ | ☐ | ☐ | ☐ | ☐ |
| Research Aptitude and Potential | ☐ | ☐ | ☐ | ☐ | ☐ |
| Scientific Background | ☐ | ☐ | ☐ | ☐ | ☐ |
| Laboratory Skills and Techniques | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ability in Oral Expression | ☐ | ☐ | ☐ | ☐ | ☐ |
| Writing Ability | ☐ | ☐ | ☐ | ☐ | ☐ |
| Perseverance | ☐ | ☐ | ☐ | ☐ | ☐ |
| Self-Reliance and Independence | ☐ | ☐ | ☐ | ☐ | ☐ |
| Originality/Creativity | ☐ | ☐ | ☐ | ☐ | ☐ |
| Social Skills | ☐ | ☐ | ☐ | ☐ | ☐ |
| Suitability for Graduate School | ☐ | ☐ | ☐ | ☐ | ☐ |

How long have you known the applicant and in what capacity? _____
Months Capacity

Name _____
Last/Family Name First/Given Name Middle Name (if any)

Address _____
Institution or Business Position/Title

_____
Street City State/Province Postal Code Country (if not USA)

/ /
Phone Number Email Address Signature Date

**Return this form and an attached letter of recommendation in a sealed envelope with the your signature or seal covering the flap to the Cedars-Sinai Medical Center Graduate Program in the address above or to the applicant.**