200 Mill Hill Avenue
Bridgeport, CT 06610
(203) 384-3022

APPLICANT REFERENCE FORM

Please check one:

NURSING PROGRAM ______   **PROGRAM OF SURGICAL TECHNOLOGY _______**

The applicant named below is a candidate for admission to Bridgeport Hospital School of Nursing. Your evaluation of the applicant is appreciated. Members of the Admissions Committee will use your comments to help them arrive at a better understanding of this applicant. Your cooperation in completing and promptly returning this form will assist both the applicant and the school.

NAME OF APPLICANT: ____
(Last Name)   (First Name)   (Middle Name)

Pursuant to Federal Law, a student admitted to Bridgeport Hospital School of Nursing is entitled to inspect this evaluation in his or her file, unless the student has signed a waiver of this right of access. However, the School does not require a waiver as a condition for admission to, receipt of financial aid from, or receipt of any other services or benefits from the School. Applicants submitting names or individuals for letters of recommendation, therefore, are free to determine whether or not they wish to waive their right to examine such evaluation.

WAIVER

The Family Educational Rights and Privacy Act permits us to request, but not require that you waive your rights to inspect this evaluation. The right, which we request that you waive, would arise if you were an enrolled student at this School and if the evaluation were maintained after your enrollment. In considering whether you will waive, please be advised that the information contained on this form will be used to evaluate you as an applicant for admission to Bridgeport Hospital School of Nursing. If you elect to waive rights of access to and review of this information, please sign your name.

__________________   ____
(Date)   (Applicant's Signature)

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