LETTER OF RECOMMENDATION

OKLAHOMA DENTAL LOAN REPAYMENT PROGRAM

Oklahoma State Dept. of Health
Dental Health Service
123 Robert S Kerr Ave, Ste 1702
Oklahoma City, OK 73102
405-426-8460
ODLRP@health.ok.gov

Applicant Information (Please type or print in black or blue ink.)

_____

Last Name First Name MI

The individual above is applying to the Oklahoma Dental Loan Repayment Program (ODLRP). This program seeks to increase access to dental care for Oklahoma Medicaid recipients and to staff faculty positions at the University of Oklahoma College of Dentistry (OUCOD). By agreeing to be part of this program, the applicant agrees to serve a minimum of 30% Oklahoma Medicaid recipients or abide by the rules and regulations of the faculty of OUCOD.

THIS FORM IS CONFIDENTIAL AND WILL NOT BE RELEASED TO THE APPLICANT.

Please print or type.
Name and Title:_____

Address:_____

City State Zip

Telephone:____(___)_____

1. In what capacity do you know the applicant (current or former supervisor, professor, etc.)?

_____

2. How long have you known the applicant? _____

3. Please rate the applicant, relative to others you have known in the same capacity in recent years, by circling the appropriate number. (1= lowest; 5 = highest). In addition, please provide an explanation as to why you rated the applicant as you did. The information you provide is instrumental in the selection process.

Evidence of understanding and providing care to the underserved.

1 2 3 4 5

Explain:_____

_____

_____

Demonstrates knowledge and acceptance of cultural diversity.

1 2 3 4 5

Explain:_____

_____

Exercises maturity in relating to patients and in making decisions.

1 2 3 4 5

Explain:_____

_____

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

1 2 3 4 5

Explain:_____

_____

4. What are the applicant's greatest strengths?

_____

_____

_____

5. Can you identify any characteristics of the applicant that might impact his/her ability to fulfill the requirements of this program?

_____

_____

_____

_____

_____

_____

6. Please use the space below to provide us with any additional information that you feel would help us make a decision.

Signature Date

Thank you for completing this form.
Please place it in a sealed stamped envelope and return to:

OKLAHOMA STATE DEPARTMENT OF HEALTH
OKLAHOMA DENTAL LOAN REPAYMENT PROGRAM
DENTAL HEALTH SERVICE
123 ROBERT S KERR AVE, STE 1702
OKLAHOMA CITY, OK 73102