

Maryland Higher Education Commission
Office of Student Financial Assistance
839 Bestgate Road, Suite 400
Annapolis, Maryland 21401
410-260-4500 800-974-0203

Maryland Department of Health and
Mental Hygiene
Office of Oral Health
201 W. Preston Street, 3rd Floor
Baltimore, Maryland 21201
410-767-3081



Recommendation Form

Applicant Information (Please print or type)

Last Name First Name MI

Social Security Number

The individual listed above is applying to the Maryland Dent-Care Loan Assistance Repayment Program (MDC-LARP). This program seeks to increase access to dental care for Maryland Medical Assistance Program (MMAP) recipients. By agreeing to be part of this program, the applicant agrees to maintain a minimum of 30% MMAP recipients in their total patient population.

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

PLEASE TYPE ALL RESPONSES

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: _____

Applicant Name

Social Security Number

Demonstrates knowledge and acceptance of cultural diversity.

1 2 3 4 5

Explain: _____

Possesses strong interpersonal skills (i.e. communication, good chair-side manners, etc.)

1 2 3 4 5

Explain: _____

Understands and appropriately utilizes the health care delivery system.

1 2 3 4 5

Explain: _____

Demonstrates strong clinical skills when treating children, especially young children.

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 others on a professional basis

1 2 3 4 5

Explain: _____

Applicant Name

Social Security Number

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. This form must be received by **September 11, 2009**. Please place it in a sealed stamped envelope and mail to:

MDC-LARP
Office of Oral Health
Maryland Department of Health and Mental Hygiene
201 W. Preston Street, 3rd Floor
Baltimore, MD 21201