



LETTER OF RECOMMENDATION
OKLAHOMA DENTAL LOAN REPAYMENT PROGRAM

Oklahoma State Dept. of Health
Dental Health Service
1000 N.E. Tenth Street
Oklahoma City, OK 73117-1299
405-271-5502
http://den.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?

