For Internal Use
Applicant#:
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Maryland Higher Education Commission
Office of Student Financial Assistance

6 North Liberty Street, Ground Suite
Baltimore, Maryland 21201
410-260-4500; 800-974-0203

Maryland Department of Health
Office of Oral Health

201 W. Preston Street, 4th Floor
Baltimore, Maryland 21201
410-767-3081

All Recommendations are due by the DEADLINE DATE: July 30, 2021

Recommendation Form

Instructions:

Applicants are required to submit a total of three recommendations. Two recommendations must come from dentists familiar with the applicant's clinical skills.

Applicants may forward the Recommendation Forms by email directly to their references. However, ONLY recommendations sent directly from the recommender's email address will be accepted.

All Recommendation Forms should be sent to the following Email address: mdh.mdclarpprogram@maryland.gov

PLEASE NOTE: This is the only form to be used for recommendations for this program. Letters will not be accepted in order to maintain consistency in evaluation for all applicants. We ask that you please type your recommendation.

Applicant Information:

Last Name:	First Name:	MI:
Telephone:	Email:	

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.

***** THE FEEDBACK PROVIDED ON THIS FORM IS CONFIDENTIAL AND WILL NOT BE RELEASED TO THE APPLICANT. *****

Recommender:

Last Name:	First Name:	MI:
Title:		Phone:
Address:		
City:	State:	Zip:

Recommendation Section:

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

2. How long have you known the applicant? ______________________________

Please rate the applicant, relative to others you have known *in the same capacity* in recent years, by selecting 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. Failure to include explanatory comments may result in a weak recommendation.**

	Low				High
	1	2	3	4	5
Evidence of understanding and providing care to the underserved. **Explain:**					
Demonstrates knowledge and acceptance of cultural diversity. **Explain:**					

	1	2	3	4	5
Understands and appropriately utilizes the health care delivery system. **Explain:**					
Demonstrates strong clinical skills when treating children, especially young children. **Explain:**					
Exercises maturity in relating to patients and in making decisions. **Explain:**					
Ability to adapt and/or be flexible when relating to others on a professional basis. **Explain:**					

1. What are the applicant's greatest strengths?

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

2. Please provide any additional information that you feel would help us make a decision.

Authorized By:____ Date:____________________________