

Please rate the Applicant on the qualities you feel you can judge in the grid below.

	Truly Exceptional	Above Average	Average	Below Average	Needs Improvement	Unknown
Ability to work with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Verbal Communication skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Punctuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependability / Reliability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Initiative / Motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maturity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Would you be comfortable having this Applicant involved in your care experience if you were a patient or visitor at our facility? Please explain: _____

Volunteers may work directly with patients, may be in proximity of highly stressful or traumatic situations, and/or may have access to limited amounts of confidential information. Are you confident this Applicant can appropriately handle him/herself in these types of situations? Please explain: _____

Is there anything else you can tell us about this Applicant? _____

What is your overall recommendation for this Applicant?

Highly Recommend Recommend Recommend with reservation Not Recommended

Recommender's Name (please print) _____

Date _____

Recommender's Signature _____

Recommendations may be mailed to:

or

Recommendations may be faxed to:

St. Cloud Hospital
 Volunteer Office
 1406 6th Ave N
 St. Cloud, MN 56303

320.255.5817

If the applicant submits this form it must be in a sealed envelope with the recommender's signature across the seal.

Thank you for providing this information.

The St. Cloud Hospital Volunteer Program admits qualified applicants without regard to race, color, national or ethnic origin, religion, sex, disability, veteran's status, sexual orientation, or age.