REFERENCE REPORT (required)

Buena Vista REGIONAL MEDICAL CENTER

Applicant Name: _____

To be completed by the person making the reference:

You have been asked to provide information in support of this applicant for a *Buena Vista Regional Medical Center Nursing Scholarship*. Please give your prompt and serious attention to the following statements. When complete, please return this form to the Applicant in a sealed envelope or mail to the Foundation Office Assistant at Buena Vista Regional Medical Center. See address listed below.

All responses will be kept confidential.

THIS FORM MUST BE RECEIVED OR POSTMARKED BY MARCH 31 TO BE CONSIDERED FOR THE SCHOLARSHIP.

The applicant's choice of a post-secondary education program is:	☐ Extremely appropriate	☐ Very appropriate	☐ Moderately appropriate	☐ inappropriate
The applicant's achievements reflect his/her ability:	☐ Extremely well	☐ Very well	☐ Moderately well	☐ Not well
The applicant's ability to set realistic and attainable goals:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
The quality of the applicant's commitment to school and community is:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
The applicant is able to seek, find and use learning resources:	☐ Extremely well	☐ Very well	☐ Moderately well	☐ Not well
The applicant demonstrates curiosity and initiative:	☐ Extremely well	☐ Very well	☐ Moderately well	☐ Not well
The applicant demonstrates honesty and exceptional character:	☐ Extremely well	☐ Very well	☐ Moderately well	☐ Not well
The applicant's respect for self and others is:	☐ Excellent	☐ Good	☐ Fair	☐ Poor

Comments: _____

_____

_____

_____

_____

_____
Print Name

_____ _____ _____ ( ) _____
Appraiser's Signature Title Date Telephone Number

Please return Reference Report to: **Buena Vista Regional Medical Center**
Katie Schwint / Foundation Department
1525 West 5th Street
Storm Lake, IA 50588