ADMINISTRATOR/PRINCIPAL RECOMMENDATION FORM
for
COLLEGIATE SCHOOL OF MEDICINE AND BIOSCIENCE

PLEASE COMPLETE, SIGN AND RETURN THIS FORM TO:

Frederick Steele
4939 Kemper Avenue
St. Louis, MO 63139
Fax: 314-244-1790
Email: Kennethera.turner@slps.org

IF NECESSARY, PLEASE USE THE REVERSE SIDE FOR ADDITIONAL COMMENTS.

STUDENT'S NAME:

SCHOOL:

____ I DO RECOMMEND THIS STUDENT FOR COLLEGIATE

____ I DO NOT RECOMMEND THIS STUDENT FOR COLLEGIATE

PLEASE CHECK THE APPROPRIATE RATING

	EXCELLENT	GOOD	NEEDS IMPROVEMENT	POOR
Academic Performance	_____ (A – B+)	_____ (B-C)	_____	_____
Assuming Responsibility	_____	_____	_____	_____
Attendance	_____	_____	_____	_____
Relationship with Peers	_____	_____	_____	_____

_____

Name of Person Completing FormSignature of Person Completing Form

_____

Principal's Signature Date and Telephone Number

TEACHER/COUNSELOR RECOMMENDATION FORM
for
COLLEGIATE SCHOOL OF MEDICINE AND BIOSCIENCE

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Attendance	_____	_____	_____	_____
Relationship with Peers	_____	_____	_____	_____

_____ **Name of Person Completing Form**

_____ **Signature of Person Completing Form**

_____ **Principal's Signature**

_____ **Date and Telephone Number**