

St. Cloud State University
Department of Social Work

BSW Academic Reference Recommendation

To be completed by the applicant:

Applicant's Name _____

Address _____

I authorize _____ to complete this recommendation with the understanding that the information will be kept confidential.

I do do not waive my right to see the completed form.
 (circle one)

TO THE RESPONDENT:

The above named person is applying for admission to the Bachelor of Social Work Program at St. Cloud State University. As part of the admission process, the applicant is requesting a reference from you. We take seriously your input into this process and appreciate your taking time to complete this reference form.

To help you understand our program the mission statement is as follows:

The mission of the Department of Social Work at St. Cloud State University is to use an anti-oppression lens, with a focus on race, class and gender, to inform both its educational environment and educational programs. Faculty, staff and students commit to an experiential and transformative educational process that will challenge them to think critically and analyze systemic inequalities in the United States and the world. This process will prepare professional social workers to work as change agents in a diverse world.

Knowledge of Applicant

1. Approximately how long have you known the applicant? _____

2. How well do you know the applicant?
 ___casually ___well ___very well

3. What was the nature of your contacts with the applicant?

Please rate the following:

	<u>Excellent</u>	<u>Good</u>	<u>Adequate</u>	<u>Poor</u>
<u>Overall Intellectual Ability</u>	(4)	(3)	(2)	(1)
<u>Writing Ability</u>	(4)	(3)	(2)	(1)
<u>Oral Expression</u>	(4)	(3)	(2)	(1)
<u>Analytical Ability</u>	(4)	(3)	(2)	(1)
<u>Commitment to Learning</u>	(4)	(3)	(2)	(1)
<u>Creativity</u>	(4)	(3)	(2)	(1)
<u>Commitment to Social Justice</u>	(4)	(3)	(2)	(1)

Please make any general comments here:

Please indicate your overall endorsement of this candidate:

- Recommend highly
- Recommend
- Recommend with reservation

Signature of person completing this form

Date

Name: (Please type or print) _____

Position/Title: _____

Organization/Company: _____

Address: _____

Telephone #: _____

PLEASE RETURN THIS FORM TO:

**Carleen Guck, Office Manager
Department of Social Work
St. Cloud State University, Stewart Hall 226
720 4th Avenue South
St. Cloud, MN 56301-4498
OR Fax to: 320-308-3285**

Thank you!