

4. List all colleges and universities attended in chronological order (most recent first):

INSTITUTION NAME	CITY/TOWN	STATE/PROVIDENCE	COUNTRY
DATES ATTENDED (MONTH AND YEAR)	FIELD OF STUDY	SPECIFY DEGREE	
INSTITUTION NAME	CITY/TOWN	STATE/PROVIDENCE	COUNTRY
DATES ATTENDED (MONTH AND YEAR)	FIELD OF STUDY	SPECIFY DEGREE	
INSTITUTION NAME	CITY/TOWN	STATE/PROVIDENCE	COUNTRY
DATES ATTENDED (MONTH AND YEAR)	FIELD OF STUDY	SPECIFY DEGREE	
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DATES ATTENDED (MONTH AND YEAR)	FIELD OF STUDY	SPECIFY DEGREE	
INSTITUTION NAME	CITY/TOWN	STATE/PROVIDENCE	COUNTRY
DATES ATTENDED (MONTH AND YEAR)	FIELD OF STUDY	SPECIFY DEGREE	

5. Please request that a copy of your official transcript be sent to **Registrar, College of Pharmacy, UAMS, 4301 West Markham - #522, Little Rock, Arkansas 72205-7122.**

6. Personal Statement

- Completed applications must include a printed or typed (250 words or less) statement that answers the following question: *Why are you interested in the profession of pharmacy?*
- Personal statement should be submitted with completed application form and sent together to **Registrar, College of Pharmacy, UAMS, 4301 West Markham - #522, Little Rock, Arkansas 72205-7122.**

8. Pell Grant Eligibility:

For applicants applying under the status of financially disadvantaged, send a copy of award letter for federal financial aid (Pell Grant eligibility) to **Registrar, College of Pharmacy, UAMS, 4301 West Markham - #522, Little Rock, Arkansas 72205-7122.** Call (501) 526-7299 with any questions.

7. Recommendations:

- Completed applications must include one letter of recommendation from a college/university instructor or advisor, a pharmacy professional, public service reference, or personal reference.
- A form is attached to be completed by the recommending party, which should be completed and sent to **Registrar, College of Pharmacy, UAMS, 4301 West Markham - #522, Little Rock, Arkansas 72205-7122.**



PCAT PREP SUMMER PROGRAM

RECOMMENDATION FORM

Section I

Applicant Information

NAME (PLEASE TYPE OR PRINT)

SIGNATURE

Section II

To be completed by a college/university instructor or advisor, and a second person of applicant's choice (preferably a pharmacist)

1. In what capacity and how long have you known the applicant?

2. How firm is the applicant's commitment to his/her proposed field of study?

3. Please rate the applicant the following areas:

	Excellent	Very Good	Average	Below Average	N/A
Leadership	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Initiative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Purpose Driven	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enthusiasm	<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"/>
Community Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Academic Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work Ethic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Please cite specific examples of how the applicant has demonstrated the qualities listed in Question 3.

5. Additional Comments

Section III

Reference Contact Information & Signature

Name: _____ Title/Position: _____

Signed: _____ Date: _____

Institution: _____

Telephone: _____ Fax: _____

Email: _____

Please return completed recommendation form to:

**Registrar, College of Pharmacy - #522
University of Arkansas for Medical Sciences
4301 West Markham
Little Rock, Arkansas 72205-7122**