



**McGill University, Faculty of Dental Medicine and Oral Health Sciences**

**Continuing Dental Education**

## Oral and Maxillofacial Radiology Mini-Residency

### *Confidential reference report*

**Applicant should fill in their name and send this form to each of two dental/medical colleagues who have agreed to supply a letter of recommendation. Completed form should be sent as an email attachment to: [conted.dentistry@mcgill.ca](mailto:conted.dentistry@mcgill.ca)**

LEGAL NAME OF APPLICANT

\_\_\_\_\_

Last Name
First Name
Middle Name

The Committee on Admissions will appreciate your estimate of the desirability of the applicant to register for an advanced course in Oral and Maxillofacial Radiology Mini-Residency. Please grade the qualities listed below by selecting a button. The appropriate column. If you prefer to write a character sketch, Please submit it on a separate Word document.

	Not observed	Outstanding	Superior	Average	Inferior
Intellectual ability					
Laboratory Competence					
Perseverance					
Resourcefulness					
Leadership					
Ability to get along with others					
Integrity					
Maturity					
Judgment and common sense					
Probability for success in chosen field					

Please indicate your opinion of this applicant as a candidate for an advanced course in forensic dentistry.

Very Desirable                      Desirable                      Fairly Desirable                      Undesirable

How long have you known this candidate?

Signature \_\_\_\_\_

Name (print) \_\_\_\_\_ Title \_\_\_\_\_

Department \_\_\_\_\_ College/University \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_