

**Return To: Marion Technical College
MESSAGE THERAPY PROGRAM
1014 S.W. 7th Road
Ocala, FL 34471**

RECOMMENDATION FORM

Applicant Name: _____
Please Print _____ Signature* _____

(*By my signature, I authorize the person below to answer the following questions to the best of their ability and submit this form to MCSRP).

NOT TO BE COMPLETED BY FRIENDS OR FAMILY. ONLY PROFESSIONAL REFERENCES. FORM MAY BE FAXED TO: (352) 671-7221.

1) How do you know this individual? _____ # of years _____

2) Do you feel this individual would adapt and excel in a health science for Massage Therapy? _____ Yes _____ No _____ Not Sure

Comments: _____

3) I have observed the following attributes in this individual (only check those that apply):

<input type="checkbox"/> Cheerfulness	<input type="checkbox"/> Self-Motivation	<input type="checkbox"/> Good Attendance	<input type="checkbox"/> Critical Thinking
<input type="checkbox"/> Maturity	<input type="checkbox"/> Self-Confidence	<input type="checkbox"/> Team Player	<input type="checkbox"/> Problem Solving
<input type="checkbox"/> Dependability	<input type="checkbox"/> Initiative	<input type="checkbox"/> Multi-Tasking	<input type="checkbox"/> Good Communication
<input type="checkbox"/> Honesty	<input type="checkbox"/> Punctual	<input type="checkbox"/> Time Management	

4) What do you feel is this individual's greatest **strength**? _____

5) In your observation, is there something that is **challenging** for this individual in which he or she could improve? _____

6) Give an example of how this individual has demonstrated **perseverance** to achieve a goal or accomplish something important. _____

7) Additional comments: _____

Signature (person making recommendation): _____

Print Name: _____ Title/Credential _____ Date _____

Contact Phone Number _____

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