

Lambda Kappa Sigma Educational Trust Educational Grant Recommendation Form For the Academic Year _____

Applicant's Name _____ Chapter _____

School or College of Pharmacy _____

Under the federal Family Educational Rights and Privacy Act of 1974, students are given the right to inspect their records, including letters of recommendation. While we consider all letters of support to be of value, we believe that letters written in confidence are of greater utility in the assessment of a student's qualifications, abilities, and promise. For the purposes of LKS grant consideration, refusal to waive access will expressly nullify the reference form and disqualify the applicant.

I waive the right to inspect this form and any attachments or written information provided. All information will be kept strictly confidential and used only by the LKS Educational Grants Committee for determination of educational grant recipients.

Applicant Signature (required) _____

The completed Educational Grant Application Form is provided by the applicant to the primary recommender; both forms are then sent directly by the recommender to the LKS International Office to maintain confidentiality. Secondary recommendations are sent independent of the application.

Submission Deadline: Postmarked no later than November 1st.

Mail to:

**Lambda Kappa Sigma
Educational Grant Committee
PO BOX 570
Muskego, Wisconsin 53150-0570**

Fax copies will be received as preliminary documentation
pending receipt of actual copies by Postal Service delivery.
Fax 262-679-4558

Two recommendations are required; please provide on the official Recommendation Form. The primary recommendation must be provided by the Chapter's Fraternity or Faculty Advisor, applicant's Academic Advisor, or Dean of Students. The secondary recommendation may also come from the above individuals or be provided by Alumnae members, the Internship Supervisor, or a Pharmacy faculty member. References will not be accepted from another student or student LKS member or someone not directly related to the fraternity or academia. (For Dr. B. Olive Cole Graduate Grant applicants, please refer to application for list of who may serve as recommendations.)

1. In what relationship have you known the applicant? For how long?

2. Please describe the level to which the applicant is a valued member of the LKS campus chapter.

...a valued member of the campus.

...a valued member of the community.

3. Describe key or special attributes that set this member apart from the others.

4. In relation to other chapter members, please rate the applicant in the following qualities by checking the appropriate line (use "U" if unknown or unable to comment):

	<u>top 10%</u>	<u>top 25%</u>	<u>top 50%</u>	<u>below 50%</u>
Academic capability	_____	_____	_____	_____
Commitment to Pharmacy	_____	_____	_____	_____
Commitment to Service	_____	_____	_____	_____
Level of Integrity	_____	_____	_____	_____
Cooperation	_____	_____	_____	_____
Maturity	_____	_____	_____	_____
Personality	_____	_____	_____	_____
Chapter involvement	_____	_____	_____	_____
Loyalty	_____	_____	_____	_____
Sisterhood	_____	_____	_____	_____
Other (list) _____	_____	_____	_____	_____
Other (list) _____	_____	_____	_____	_____
Other (list) _____	_____	_____	_____	_____

5. Comment on applicant's future professional plans (if known).

6. Brief additional comments (if desired).

Recommender's Information: Primary_____ Secondary_____ Date _____

Signature_____ Date_____

Name_____ Title_____

Work Phone_____ E-mail_____