

UNIVERSITY OF COLORADO AT DENVER SCHOOL OF DENTISTRY

**DENTAL HYGIENE PROGRAM
RECOMMENDATION FORM**

I. To Be Completed By Applicant: (Please print or type)

Name of Applicant _____

Address of Applicant _____

Name of Person(s) Requested to Provide Recommendation:

The Family Educational Rights and Privacy Act provide that each applicant will have the right of access to his/her letters of recommendation. Check one box and sign below the appropriate statement. Though it is not a requirement of this application, the applicant may voluntarily waive this right; thus, the recommender is assured that his/her recommendation will remain confidential.

_____ I hereby **waive my right of access** to this information and authorize the above-named person to provide a candid evaluation and all relevant information to the University of Colorado at Denver School of Dentistry. By waiving this right of access, I understand that the University of Colorado at Denver School of Dentistry will hold this completed form in confidence from me to the extent permitted by law.

Signature _____ Date _____

_____ I **do not waive my right of access** to this recommendation, but authorize the above-named person to provide a candid evaluation including all relevant information to the University of Colorado at Denver School of Dentistry.

Signature _____ Date _____