

Health Information Administration Department
College of Health Sciences

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HEALTH INFO ADMINISTRATION RECOMMENDATION FORM

To the Applicant: Fill in your name and the name of the program before forwarding this form to the individual who will complete this evaluation:

Name of Applicant: (Please Print): _____

The person whose name appears above has applied to the _____

Applicant Name: _____

2. Do you Highly Recommend Not Recommend

3. How long have you known applicant? _____

4. In what capacity have you known Applicant? _____

Name of person completing form (Type or Print) : _____

Signature: _____ Date: _____

Title: _____

Place of Employment: _____

Address: _____

City/State/Zipcode: _____

Phone: _____ Email: _____

5. Additional Information: Please list any additional information that may assist in the evaluation of the applicant for admission or submit a separate document.

PLEASE MAIL TO: Department of Health Information Administration
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 Chicago State University
 BHS 427
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