Cleveland Clinic

The Robert D. Kruse Memorial Scholarship
Waiver Form

To the applicant: Please complete the following:

Name: _____ Date of Graduation: _____
(Last, First, Middle or Maiden Name)

The applicant should sign and date <u>one</u> of the following statements:

11) I wish to have access to this letter and I understand that under the Family Education Rights to Privacy Act of 1974, 20 U.S.C. 1232 g (a) (1), I have the right to read this recommendation.

Applicant's Signature: _____ **Date:** _____

2) I wish this letter to be confidential and I hereby waive any and all access rights granted me by the above laws to this recommendation.

Applicant's Signature: _____ **Date:** _____

**Please note: Two recommendation forms are required, letters may also be sent in addition to the required form. One recommendation must come from a faculty member of your health science program.*

Please do <u>NOT</u> staple any documents.
Please do <u>NOT</u> print any documents double-sided.

Cleveland Clinic

The Robert D. Kruse Memorial Scholarship
Recommendation Form

Instructions for College Faculty

The student identified below is applying for the Robert D. Kruse Memorial Scholarship at the Cleveland Clinic. Your recommendation is required to complete the application. The Robert D. Kruse Memorial Scholarship was created by Alice Kruse in memory of her husband, Robert D. Kruse, DPE, Director of Cleveland Clinic's School of Physical Therapy from 1956 to 1962. Dr. Kruse, who was visually impaired, was very energetic. He helped all students, but was especially encouraging and supportive to those students who were interested in learning and had to work to continue their education. His goal was to ensure students advance as far as their education, skills and talents could take them.

Student Name: _____ Expected Date of Graduation: _____

Please rate the Applicant in the following categories using the Likert scale below:

	5 Excellent	4	3 Neutral	2	1 Poor	UA (Unable to Answer)
Quality of Work	☐	☐	☐	☐	☐	☐
Innovation	☐	☐	☐	☐	☐	☐
Teamwork	☐	☐	☐	☐	☐	☐
Service	☐	☐	☐	☐	☐	☐
Integrity	☐	☐	☐	☐	☐	☐
Compassion	☐	☐	☐	☐	☐	☐
Initiative/Motivation	☐	☐	☐	☐	☐	☐
Professionalism	☐	☐	☐	☐	☐	☐
Perseverance	☐	☐	☐	☐	☐	☐
Willing to Help Others	☐	☐	☐	☐	☐	☐
Work Ethic	☐	☐	☐	☐	☐	☐

	5 Highly	4	3 Neutral	2	1 Not	UA (Unable to Answer)
Your Recommendation of the Applicant for the Kruse Scholarship	☐	☐	☐	☐	☐	☐

Relationship to the Applicant (e.g. program director, clinical instructor, biology instructor, academic advisor, etc.): _____

How long have you known the Applicant? _____

Has or will the Applicant have a clinical rotation at a Cleveland Clinic facility? ☐ Yes ☐ No If Yes, please identify: _____

Additional Information: Indicate Applicant's strengths and areas that require further development.

Strengths:
Areas Requiring Further Development:

Your Name/Title: _____

Place of Employment: _____

Phone Number: _____ Email Address: _____

Signature: _____ Date: _____

Return Completed Waiver and Recommendation Forms directly to:

Cleveland Clinic
Education Institute
Health Professions' Education Council
9500 Euclid Ave. / NA31
Cleveland, OH 44195

Thank you for your assessment.