

**STUDENT EVALUATION FORM – 2<sup>ND</sup> YEAR STUDENTS ONLY**

Name of Program: \_\_\_\_\_

Name of Student: \_\_\_\_\_

1. To the best of your knowledge, is the above student related to any of the following:

- |   |            |
|---|------------|
| Director of the school                                    | Yes__ No__ |
| Full-Time faculty members of the school                   | Yes__ No__ |
| Full-Time faculty members of the Dept. of Ophthalmology   | Yes__ No__ |
| JCAHPO Education & Research Foundation Board of Directors | Yes__ No__ |

2. How long have you known the applicant? \_\_\_\_\_

3. Does the applicant behave in an ethical and moral manner while at your facility? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Is the applicant's academic performance:  
\_\_\_\_\_ Fair    \_\_\_\_\_ Good    \_\_\_\_\_ Excellent

5. Please describe circumstances which impact the applicant's ability to finance his/her education and his/her apparent need for financial assistance from the JCAHPO Education & Research Foundation?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. What is the applicant's motivation to complete training and pursue a career as an OMP?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. Other comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature (Program Director)

\_\_\_\_\_  
Date

**COMPLETION OF THIS FORM BY THE PROGRAM DIRECTOR (OR A LETTER ADDRESSING EACH OF THE QUESTIONS ABOVE) FOR EACH STUDENT SUBMITTING AN APPLICATION IS REQUIRED. PLEASE RETURN TO:**

**JCAHPO EDUCATION & RESEARCH FOUNDATION  
2025 WOODLANE DRIVE  
ST. PAUL MN 55125-2995**