LEXINGTON MEDICAL CENTER

Nurse Scholars Program Clinical Performance Evaluation

STUDENT AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize you and your institution to provide the information requested and release you and your institution from any liability resulting therefrom. All information provided to Lexington Medical Center will be held in confidence and used for the specific purpose of the Nurse Scholar Program application process.

Student Name:_____

STUDENT PERFORMANCE EVALUATION (to be completed by nursing faculty)

School of Nursing:_____ Faculty/Instructor:_____

Please use a scale of 1 to 5 (1 = Unsatisfactory, 5 = Excellent) to rate the student on the following performance criteria:

_____ Attendance	_____ Organizational Skills
_____ Initiative	_____ Integrity
_____ Quality of Work	_____ Cooperation
_____ Attitude	_____ Relationship with Others
_____ Teamwork	_____ Communication Skills

Comments/Strengths/Areas for Improvement:

I would recommend this student for the Lexington Medical Center Nurse Scholars Program: ☐ Yes ☐ No

If no, why not:

Faculty/Instructor Signature:_____ Date:_____

***Email this release of information and evaluation form to:**

LMCNurseScholarsProgram@lexhealth.org

If you have any questions, please contact (803) 791-2334.