

**University of Minnesota School of Dentistry
Faculty Reference Request and Authorization Form**

Name: _____		
Last	First	Middle Initial
Address: _____		
Telephone: _____	Student I.D. Number: _____	
Year of Graduation: _____	Date of Birth: _____ <small>(If Student ID is unavailable)</small>	
Faculty Member that I wish to have serve as a reference for me: _____		

The purpose(s) of the reference are: (check all applicable)

Application for employment

Other (Specify)

All forms of scholarships or honorary awards

Admission to another education institution

The reference may be given in the following forms: (Check one or both)

Written

Oral

I authorize the above person to release information and provide an evaluation about any and all aspects of my academic performance at the University of Minnesota to the following: (check all applicable)

All prospective employers

Specific employers
(list on reverse)

All educational institutions
to which I seek admission

Specific education institutions
(list on reverse)

All organizations considering
me for an award or scholarship.

Specific Organization
(list on reverse)

This authorization to provide references is valid until: (up to one calendar year) _____

Under the Family Educational and Privacy Rights Act, 20 U.S. C. 1232(g), you may, but are not required to waive your right of access to confidential references given for any of the purposes listed on this form above. If you waive your right of access, the waiver remains valid indefinitely. Check the appropriate space below:

I hereby waive the right of access to this recommendation.

I do not waive the right of access to this recommendation.

Signature

Date