



Letters of Recommendation CONFIDENTIALITY AGREEMENT

No letter of recommendation will be processed without a completed and signed agreement!

Note: Not intended for use by students enrolled in an LPS Post-Baccalaureate program. If you are an LPS student please discuss your credentials file options with your LPS advisor.

APPLICANT INFORMATION *ALL FIELDS TO BE COMPLETED BY APPLICANT*

PENN ID: GRAD YEAR: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

PRONOUNS: _____ EMAIL: _____

INTENDED USE OF LETTER OF RECOMMENDATION:

- ALLOPATHIC MEDICAL SCHOOL (MD) MD / PHD PROGRAM
- OSTEOPATHIC MEDICAL SCHOOL (DO) DENTAL SCHOOL

RECOMMENDER INFORMATION *ALL FIELDS TO BE COMPLETED BY APPLICANT*

LAST NAME: _____ FIRST NAME: _____

PROFESSIONAL TITLE: _____ EMAIL: _____

INSTITUTION: _____

As per the *Family Educational Rights and Privacy Act of 1974 (FERPA)*, I understand that I may view this evaluation unless I explicitly **waive** my right to do so below:

- CONFIDENTIAL:** I waive my right to view this evaluation
- NON-CONFIDENTIAL:** I do not waive my right to view this evaluation

Applicant Signature _____ Date

WE CANNOT ACCEPT TYPED SIGNATURES

ATTENTION RECOMMENDERS:

Please ensure the letter is on *official letterhead, dated, and signed* (typed signatures cannot be accepted). Unless explicitly asked by the student, address all letters to the attention of a *general medical school admissions board*.

PLEASE ATTACH FORM TO LETTER AND SUBMIT VIA EMAIL:

vpul-letters@pobox.upenn.edu

For more information:
<https://careerservices.upenn.edu/advice-writing-medical-school-letters-of-recommendation/>

UNIVERSITY OF PENNSYLVANIA NONDISCRIMINATION STATEMENT

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