** DO NOT MAIL – RETURN TO EMPLOYEE**

HOSPITAL REPRESENTATIVE RECOMMENDATION FORM

CAPE FEAR VALLEY HOSPITAL AUXILIARY
HEALTH CARE CAREER EMPLOYEE SCHOLARSHIP

Employee's Name:_____

Phone Number:_____ Cell Number:_____

E-Mail Address:_____

(The above information is to be completed by the employee.)

On a separate sheet of paper, please type your comments on how the employee exemplifies the following qualities. Your total comments should not exceed 300 words.

DEPENDABILITY – INITIATIVE – INTEGRITY – ADAPTABILITY – LEADERSHIP – AND CONCERN FOR OTHERS

Also, please include any additional comments about why the employee should be selected for the Scholarship.

Signature and Title:_____Date:_____

Printed Name:_____

Address:_____

_____

City State Zip Code

Phone Number:_____ Cell Number:_____

THIS LETTER MUST BE SUBMITTED TO THE EMPLOYEE IN A SEALED ENVELOPE WITH YOUR SIGNATURE WRITTEN ACROSS THE SEAL.