REVIEW FORM

University of Vermont
College of Medicine
Department of (Department)

DATE: _______________________

PLEASE RETURN THIS FORM ALONG WITH YOUR LETTER TO:

Name
Chair, Department of (Department)
Address

SUBJECT: Relationship to Candidate Form

Name of Candidate: __________________________

A. Relationship to the candidate and his/her work:

Present or past colleague (at same institution as a student, Postdoctoral fellow or faculty member)    _______

Past mentor    _______

Collaborator (worked with, or co-authored papers)    _______

None of the above    _______

B. Knowledge of candidate’s work based primarily on:

His/her publications and CV     ________

Scientific presentations     ________

Personal knowledge and discussions     ________

Participated on review panels (study section, advisory Boards, etc.)     ________

_________________________________  _____________
Signature of Reviewer     Date

_________________________________
Printed Name of Reviewer

Revised June 2016