

**DEPARTMENT OF MEDICINE
RECOMMENDATION LETTER REQUEST**

Please write legibly!

Name: _____

Fellowship (subspecialty): _____

Practice or Residency (specialty): _____

Deadline (Location/Date): _____

*Please indicate your preference of for Departmental letter writer below:

- | | | |
|-------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Dr. Best | <input type="checkbox"/> Dr. Knight | <input type="checkbox"/> Dr. Steinberg |
| <input type="checkbox"/> Dr. Hagman | <input type="checkbox"/> Dr. Rhoads | <input type="checkbox"/> Dr. Weigle |

At least two weeks notice is required to meet with you, review your file, and prepare your letter. If you need letters sent to multiple institutions, please provide your letter writer with a complete list of facilities and accurate mailing addresses.

Release of Information

I authorize access to my resident file including evaluations and confidential letters of recommendation for the purpose of preparing a Department of Medicine letter of recommendation.

Signed: _____ Date: _____

****Remember to provide your letter writer a CURRENT CV****

**Return to:
Medicine Residency
University of Washington
Box 356421
FAX: 206-685-8652**