

Allied Health Programs – Request for Academic Rating Form

The *Academic Rating Form* is utilized by the Bossier Parish Community College Allied Health Programs in the clinical selection process. *Academic Rating Forms* are not available to students. *Academic Rating Forms* are e-mailed to only the instructor(s) indicated by the student. **The student must provide the e-mail address and contact information for each indicated instructor.**

It is **STRONGLY SUGGESTED** that the student **submit** their *Request for Academic Rating Form* **as soon as possible**. Upon receipt of a *Request for Academic Rating Form*, the indicated instructor(s) will be contacted by e-mail and asked to complete an *Academic Rating Form* on the student and/or it will result in an archived academic rating form that was completed by your ALHT 109 instructor being forwarded to the selection committee.

It will be the student's responsibility to follow up with the instructor indicated on the *Request for Academic Rating Form* to ensure they have completed and submitted the *Academic Rating Form* by the program's application deadline. **Failure to have the *Academic Rating Form* submitted by the program application deadline may result in the student's application becoming ineligible for consideration.**

To confirm receipt of the completed Academic Rating Form, you can contact Tonia Sharp either by phone at (318) 678-6110 or by email at tsharp@bpcc.edu.

To submit your Request for Academic Rating, print the form, sign the consent to release information part then return it to Tonia Sharp.

Bossier Parish Community College
Attn: Tonia Sharp – Academic Rating Request
6220 East Texas Street
Bossier City, LA 71111

Consent to Release Information

I, _____, give the instructor I have indicated on the Request for Academic Rating Form, permission to release my Academic Rating to the selection committee(s) of the clinical program(s) to which I am applying.

Signature: _____ Date: _____

Applicant Information

To which program(s) are you applying at this time? (check all that apply) Occupational Therapist Assistant

Physical Therapist Assistant

Name: _____ Applicant's CWID#: _____

Phone number: _____ Address: _____

E-mail: _____ City, State, Zip: _____

ALHT 109 Information

Instructor's Name: _____ Semester & Year of ALHT 109 _____

Phone Number: _____ Instructor's E-mail: _____

Instructor (only use if ALHT 109 more than 5 years old)

Instructor: _____ Instructor's Email: _____

Phone number: _____ Name of College/University if different than BPCC: _____

Semester & Year of instruction: _____ Course of Instruction: _____