



CITY CARE INSTITUTE RECOMMENDATION

Applicant Name: _____
LAST FIRST MIDDLE

Address: _____

Phone: Home: () _____ Mobile: () _____ Work: () _____

Email: _____ Fax: _____

To the APPLICANT: This form should be complete by a pastor or professional **and returned by him/her** directly to City Care Institute. I acknowledge that this is confidential statement is being submitted to City Care Institute with the understanding that its contents will not be shared with me. I hereby waive my right to see the confidential statement submitted on this form.

Signature

To the RECOMMENDER: Each applicate for admission to the City Care Institute Chaplaincy Program must submit a recommendation from a pastor and professional. Serious consideration will be given to your comments, therefore, please complete the form carefully. Since a candid evaluation is requested, your comments will be held in strictest confidence. The recommendation should be returned directly to the mailing address above (right corner).

Return completed form to:
City Care Institute
310 N Indian Hill, #154
Claremont, CA 91711

1. How long have you known the applicant: _____
2. In what capacity? _____
3. How well do you know him/her?

By name/sight Casually-Few personal contacts Fairly well Very well

