# RECOMENDATION LETTER

COMMUNITY HEALTH CHOICE

## NAME OF SCHOOL FACULTY MEMBER

_____

Please explain why this student would be successful in a post-secondary education setting (certification, vocational training, apprenticeship, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Faculty Member Signature _____ Date _____ / _____ / _____

Applicant Name (Print) _____ Member ID _____

Applicant Signature _____ Date _____ / _____ / _____

## FOR OFFICE USE ONLY

Health Plan _____ Years of Membership _____

Application Reviewed By _____ Date of Review _____ / _____ / _____

Completed Recommendation Letters can be emailed to Life Services@CommunityHealthChoice.org



4888 Loop Central Dr. Suite 600 | Houston, TX 77081 | LifeServices@CommunityHealthChoice.org | 713.295.2437