



REFERENCE INFORMATION

Applicant: _____

Employment dates: _____
FROM TO

I authorize, _____ of _____
SUPERVISOR NAME HOSPITAL NAME
to release information about me for the purpose of supplying a reference check.

Applicant signature date

| | EXCELLENT | GOOD | FAIR | POOR |
|-----------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Adherence to Policies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dependability | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Attendance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Attitude | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Quality of Work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Initiative | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Relationship with | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Employees | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Eligible for Re-hire? YES NO

If not eligible, why? _____

Name of person completing form title

Signature date