Health Management SOLUTIONS

Professional Reference Form

APPLICANT NAME: _____

Last 4 digits of your Social Security #: _____

Name of Person to Contact: _____

Phone: _____ E-mail Address: _____

Name of Facility: _____

Dates of Employment: From: _____ To: _____ Position Held: _____

Reason for leaving: _____

Area of Work:_____ Clinical Specialty: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I specifically authorize the persons listed above to release information for the purpose of verifying my past employment and any related information I have stated herein. I hereby release Health Management Solutions, Inc. and the persons or institutions listed above from any claims, damages, or liabilities that I, my heirs and assigns may have which may arise from the release of any of the above information. I have read the foregoing release and authorization, understand its contents, and understand that I have a right to receive a copy of any findings resulting from this authorization.

Dated: _____ **Signature of Applicant :** _____

***References must be from a person in a managerial position**

Reference Contact Person

Please indicate whether the above information is correct

Dates of employment: ☐ Yes ☐ No

Is the person available for re-hire? ☐ Yes ☐ No

Additional comments regarding the applicant's professional abilities:

_____

_____

Form may be: Fax.- **(925) 258-0107** - E-mail **admin@healthstaffing.com**.

Verified By: _____ Date_____

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