

Name (Please Print) Last First Initial Phone - home other

Address (city, state, zip) Major Cross Street Personal Data

Social Security Number Alien I.D. Number Date of Birth Sex (circle) M F

High School Name and Location Marital Status Children - Ages M F

Professional Data General Health Status

Nursing School or College Name Date of last Physical Exam

Address (City, State, Zip) Notify in Case of Emergency Phone

Degree / Certificate AN, LVN, License No. Exp. date

Other Education (incl. special courses, special skills, etc.) Other License No. Exp. date

1. Current or Last Employer 3. Prior Employer

Street Address Phone: Street Address Phone:

City, State, Zip City, State, Zip

Job Title Salary Date Worked From To Job Title Salary Date Worked From To

Name Used While Employed May we contact to obtain reference? Name Used While Employed

Job Responsibilities Job Responsibilities

Immediate Supervisor Supervisor Reason for leaving Reason for leaving

Prior Employer 4. Prior Employer

Street Address Phone: Street Address Phone:

City, State, Zip City, State, Zip

Job Title Salary Date Worked From To Job Title Salary Date Worked From To

Name Used While Employed Name Used While Employed

Job Responsibilities Job Responsibilities

Supervisor Supervisor Reason for leaving Reason for leaving

1. Reference Professional References

Address Phone: Address Phone:

Relationship Address Relationship

2. Reference Address Relationship

Address Phone: Address Phone:

Relationship Address Relationship

How did you hear about Associated Health Professionals? Date Completed: Signature: Payroll:



**Associated Health Professionals, Inc.**



**PROFESSIONAL REFERENCE CHECK**

*(Please have form filled completely by your reference before returning to AHP)*

I authorize \_\_\_\_\_  
(Name and Title of Professional Healthcare Manager) (Telephone Number)

from \_\_\_\_\_  
(Facility Name and Address)

to release information about me regarding my employment while at that facility to Associated Health Professionals, Inc. for the purpose of supplying a reference check.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PERFORMANCE EVALUATION**

(Name of Healthcare Professional) \_\_\_\_\_ has applied for a nursing position with Associated Health Professionals, Inc. and has given us your name as a professional reference. We would appreciate it if you would evaluate the applicant's past performance by filling in the appropriate boxes below, and make any additional comments you feel might assist us in making our decision regarding hiring this healthcare professional. Your comments will be kept in strict confidence.

Name and Title of Reference \_\_\_\_\_ Telephone \_\_\_\_\_

Facility Name \_\_\_\_\_

Address: \_\_\_\_\_ City, State, ZIP Code \_\_\_\_\_

Employment Dates: From \_\_\_\_\_ To \_\_\_\_\_ Title During Employment \_\_\_\_\_

Area(s) / Department(s) Worked \_\_\_\_\_

	Exceeds Expectations	Meets Expectations	Meets Some Expectations	Does Not Meet Expectations	Comments
Quality of Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Professionalism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional Stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flexibility	<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"/>	_____
Enthusiasm Toward Job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Leadership Ability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Communication Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Attendance/Punctuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Customer Service Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Reason this healthcare professional left your facility:  Terminated  Lay-off  Resigned  Completed assignment

Comments (please continue on other side of this form if needed) \_\_\_\_\_

Would you hire this healthcare professional again?  Yes  No

Signature and Title \_\_\_\_\_ Date \_\_\_\_\_

Please return this form to:	<b>Associated Health Professionals, Inc</b> 6095 Bristol Parkway - Ste. 200 Culver City, CA 90230	<b>Fax: 310.645.3034</b>
Tel. 800.428.4823		



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Emotional Stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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