PROFESSIONAL REFERENCE REQUEST

CONSENT BY EMPLOYEE: _____
Name used while working at this facility

Facility Name: _____

Street Address: _____

City, State, Zip: _____

Manager/Supervisor: _____ Name _____ Title _____ Phone Number

APPLICANT: Please complete this reference request by completing the blanks above to correspond with your employment on this application, and sign the line below. Give this form to your reference to complete and return to us directly, or send completed forms with your application.

The facility listed above has my consent to release any information to *O'Grady Peyton International* pertaining to my employment on the application. I also authorize *O'Grady Peyton International* to disclose this reference to any of its Client institutions and *O'Grady Peyton International* affiliates.

_____ Signature

_____ **Last 4 Digits** of Your Social Security Number

EMPLOYER: The individual name above has applied for employment with *O'Grady Peyton International*. In order to maintain Joint Commission competency standards, we ask that you provide the information requested below. Your response will be held in the strictest confidence. Please fax the completed form to our secure fax number: **(858) 523-6650** or return to the applicant listed above. Thank you for your assistance.

EMPLOYEE PROFILE: :

Employee's name _____ Position held: _____

Employed from: _____ to _____

Is employee eligible for rehire? ☐ Yes ☐ No If no, please explain: _____

FACILITY/UNIT PROFILE:

Unit/Floor/Dept. _____ Specialty _____ # of beds _____ Avg. patient caseload _____

☐ Teaching ☐ Non-Teach # of beds in facility _____ Charge Experience? ☐ Yes ☐ No

UNIT DESCRIPTION: _____

PROFESSIONAL REFERENCE:

KEY: A = Superior B = Exceeds Standards C = Meets Standards D = Does Not Meet Standards

	A	B	C	D		A	B	C	D
Adaptability					Professionalism				
Communication skills					Quality of work				
Competency					Reliability/Attendance				
Follows safety/emergency protocols					Teamwork/cooperation				
Initiative					Thorough/accurate documentation				

AGE SPECIFIC COMPETENCY (please check the patient population(s) the employee served):

- ○ Neonates/newborns
- ○ Infants
- ○ Toddlers
- ○ Preschoolers
- ○ Older children
- ○ Adolescents
- ○ Young adults
- ○ Middle adults
- ○ Older adults/geriatrics

COMMENTS: _____

Name of evaluator: _____ **Signature:** _____

Title: _____ **Phone Number:** _____ **Date:** _____

Email Address: _____

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