

**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 *Medical Express* pertaining to my employment on the application I also authorize *Medical Express* to disclose this reference to any of its Client institutions and *Medical Express* affiliates.

Signature \_\_\_\_\_ Social Security Number \_\_\_\_\_

EMPLOYER: The individual name above has applied for employment with *Medical Express*. In order to maintain JCAHO 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: (800) 282-0328 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-Teaching # 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
- Preschoolers
- Young adults
- Infants
- Older children
- Middle adults
- Toddlers
- Adolescents
- Older adults/geriatrics

**COMMENTS:** \_\_\_\_\_

Name of evaluator: \_\_\_\_\_ Signature: \_\_\_\_\_

Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_