

# Allen Medical Staffing, Inc.

## Employment Verification

Name of Applicant: \_\_\_\_\_  
 Position Applied for: \_\_\_\_\_  
 SS: \_\_\_\_\_

<b>OFFICE USE ONLY</b> VERIFIED BY _____ Date _____
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## Contact Information

The person referred to below has applied for a position at Allen Medical Staffing Inc. Would you kindly fill in the blanks below and return the information requested. This information will be kept strictly confidential. Thank You.

Name of Person Filling out form/Title: \_\_\_\_\_

Position Held by Applicant: \_\_\_\_\_

Relationship to Applicant: ( ) Supervisor ( ) Employer ( ) Other: \_\_\_\_\_

Dates of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Would you rehire? ( ) Yes ( ) No If No, Why? \_\_\_\_\_

<i>Character of Applicant</i>	<b>Satisfactory</b>	<b>Unsatisfactory</b>	<b>Unable Evaluate</b>
Quality of work			
Productivity			
Attendance			
Punctuality			
Initiative			
Cooperation			
Dependability			
Accepts constructive Criticism			
Additional Comments:			

<b>APPLICANT RELEASE OF INFORMATION:</b>	
I hereby release from all liability the company, institution or people named above and authorize them to release all information regarding my employment with them.	
* APPLICANTS SIGNATURE:	* Date: