PROFESSIONAL / WORK REFERENCE (RN/LVN)

Name:_______________________________ Dates Worked: From __________to_________

Facility Name:_____________________________________(Phone)___________________

Address:____

Street Address City State ZIP CODE

Supervisor/Manager:____

I hereby authorize release of information pertinent of my previous employment as requested by __________________________________.

____

RN/LVN Signature

	EXCELLENT	GOOD	FAIR	POOR
1) Clinical Skills	_______	______	______	_____
2) Ability to Prioritize	_______	______	______	_____
3) Flexibility to Work	_______	______	______	_____
4) Assignments	_______	______	______	_____
5) Initiative and Enthusiasm	_______	______	______	_____
6) Ability to Relate to Patients	_______	______	______	_____
7) Cooperation with Staff	_______	______	______	_____
8) Ability to take charge duty	_______	______	______	_____
9) Punctuality	_______	______	______	_____

Eligible for Rehire? **Yes ____** **No ____**

If no, please explain why? ____

____

Verifier's Name : ____________________________________

Verification Date:______________________________