

IRON COUNTY MEDICAL CARE FACILITY

1523 Highway US 2
Crystal Falls, MI. 49920

REFERENCE REQUEST FORM

Supervisors Name: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Dear Employer,

This is a request for information concerning a present/former employee, _____, that has applied for a position with our facility. It would be greatly appreciated if you would take a moment to answer a few questions regarding this employee.

This applicant states their position held with your company was _____ and their period of employment was from _____ to _____.

*

Signature of Applicant

*

Date

Person making request – Title

Date

PLEASE USE THE FOLLOWING RATING SYSTEM IN REFERENCE TO THE APPLICANT

1 = POOR 2 = BELOW AVERAGE 3 = AVERAGE 4 = ABOVE AVERAGE 5 = EXCELLENT

- 1. Attendance & Punctuality _____
- 2. Initiative _____
- 3. Work Ethic _____
- 4. Courtesy _____

- 5. Team Work _____
- 6. Quality of Work _____
- 7. Quantity of Work _____

Comments: _____

Signature

Date

Thank you for your time in answering these questions – Please return in the envelope provided ASAP, so there is no delay in our decision regarding this applicant.

*** Applicant sign and date only**

Approved: 01/27/97