



**LETTER OF REFERENCE FOR
MATRIX HEALTHCARE SERVICES, INC.
PHONE: 866.NURSE.44 FAX: 866.NURSE.73**

APPLICANT: PLEASE SIGN AND RETURN THIS FORM ONLY. PHONE NUMBER AND REFERENCE NAME TO BE COMPLETED BY MATRIX HEALTHCARE TO VERIFY REFERENCES VIA FAX OR MAIL.

Reference Name: _____
Facility of Reference: _____
Address: _____

Date: _____

Phone: _____

Matrix Healthcare Representative

Date

Reference Authorization and Waiver:

I authorize Matrix Healthcare Services, Inc. to contact my former employers and references I have provided. I further agree to hold harmless from any and all liability to Matrix Healthcare and any other entities or individuals who provide information to Matrix Healthcare. A photocopy of this authorization and waiver shall be considered as legally valid as the original and may be sent to my former employers and references provided as a statement of my intent to hold them harmless for the results of references given. I certify that I have read and understand this statement of authorization and waiver.

Applicant Signature

Date

Please Print Name

Social Security Number

APPLICANT: DO NOT WRITE BELOW THIS LINE

The candidate listed below has applied to Matrix Healthcare Services, Inc. for placement assistance and your facility has been submitted as a former employer for reference referral purposes. The serious nature of our patients and clients is such that any consideration of the individual by Matrix Healthcare is dependent upon receipt of satisfactory references. We would, therefore, appreciate your cooperation in replying to the questions listed below. Please be assured that your response will be kept in the strictest confidence. Thank you in advance for this courtesy.

Applicant Name: _____

Position Held: _____

Unit(s) Worked: _____

Full Time Part Time Per Diem
 Core Staff Travel Assignment Agency

Employment Dates: From: _____ To: _____

Eligible for Rehire: Yes No

Reason for Leaving: _____

<i>Personal Evaluation Criteria:</i>	<i>Exceeds Expectations</i>	<i>Meets Expectations</i>	<i>Did Not Meet Expectations</i>
Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooperation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to Get Along with Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance and Punctuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct with Patients/Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General Nursing Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing Judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature: _____ Title: _____ Date: _____