Heart of Gold Senior Services
1508 Lake Alfred Road, Lake Alfred, FL 33850
863-595-8927/863-875-6014

Confidential Request for Work Reference

To: _____
(Name of Company or previous employer)

_____
(Street Address/City/State/Zip)

_____ _____
(Business Phone#) (Business Fax#)

Print your name: _____ Last 4 of SS# _____

Registrant Signature: _____ Date: _____
_____

One of your current/ former employees is in Process of registering as an Independent Contractor with Heart of Gold Senior Services. We would appreciate your taking the time to complete this form at your earliest convenience and return to our office. Information provided by you is considered confidential and will be treated in accordance with confidential regulations.

Dates of Employment TO: _____ From: _____

Position Held: _____

Reason for Leaving _____

Would you Rehire: _____ IF "NO", Please Explain: _____
_____

Please rate the registrant on the following:

	Below Average	Average	Above Average	NO Knowledge	Comments
Ability to work with others:	☐	☐	☐	☐	
Appearance:	☐	☐	☐	☐	
Attendance:	☐	☐	☐	☐	
Cooperation:	☐	☐	☐	☐	
Job Knowledge:	☐	☐	☐	☐	
Judgement:	☐	☐	☐	☐	
Quality of Work:	☐	☐	☐	☐	
Overall rating	☐	☐	☐	☐	

Please provide us with any other pertinent information on this application:
_____

_____ _____
Employer Signature/Title Date

1. Name: _____ Phone# _____

   Address _____/_____ Relationship (friend, co-worker, clergy, etc) _____
   _____

2. Name: _____ Phone# _____

   Address _____/_____ Relationship (friend, co-worker, clergy, etc) _____
   _____

3. Name: _____ Phone# _____

   Address _____/_____ Relationship (friend, co-worker, clergy, etc) _____
   _____

I am aware that any omissions, falsifications, mistreatments or misrepresentations may disqualify me from consideration and maybe grounds for not being called for referrals. I understand that any information I give may be investigated as allowed by law**. I consent to the release of information contained in my registration file (which may include, but not limited to, licenses, certificates, medical information, background screening, references and other documentation) when requested by a potential client or referral source. I consent to dis release via telephone, facsimile, emails or mailing services. I agree to let the company access my level 2 criminal background information and verify my healthcare license/certification at the time of my registration and annually thereafter as long as I remain on the active registry list.** I certify that to the best of my knowledge and belief all of the statements contained herein and on any attachments are true, correct, and complete made in good faith.

Registrant Signature_____ Date _____

(Office use only)
Date File Completed: _____
Initials of Person Completing File: _____