

To: _____

George Ade Memorial Health Care Center
3623 East State Road 16
Brook, IN 47922-8800
Phone: (219)275-2531
Office Fax: (219)275-7472

To Whom It May Concern:

The applicant named below is being considered for employment as _____ with George Ade Memorial Health Care Center.

The applicant listed you or your organization as a former place of employment or as a personal reference. In accordance with the release signed by the applicant below, please provide the information requested and return this form to us by mail or by fax at (219) 275-7472.

Sincerely,
George Ade Memorial Health Care Center

Name of Applicant: _____

Name while employed if different from above: _____

Last 4 digits of Social Security Number: XXX-XX-_____

Applicant's Authorization

I am seeking employment with George Ade Memorial Health Care Center in Brook, Indiana and hereby give my permission to you to release the following information and any further waive and release you from any claim of action I may have against you to the extent that such information furnished GAMHCC is an accurate reflection of my work record. I hereby waive and release any claim of action I may have against GAMHCC regarding the receipt of the following information to the extent that such information is used in a confidential manner solely for the legitimate purpose of determining suitability for employment. A photocopy or other reproduction of this original will be valid.

X _____
Signature of Applicant

(For office use only)

RECORD OF EMPLOYMENT

Employed from: _____ to _____

Position held: _____

Reason employment ended: _____

Would you rehire Applicant? _____ Yes _____ No

Any Comments: _____

Signature Title Date