

# Managing the Dental Team

## ADA's Guidelines for Practice Success™ (GPS™)

### REFERENCE CHECK FORM

(To be mailed/faxed to applicant's reference(s) for completion and returned by mail/fax.)

To Whom It May Concern:

\_\_\_\_\_ (applicant name) has applied for employment with our company and has given us the information stated below concerning his/her employment with your organization. This applicant has authorized us to communicate with you for verification of this information and to receive such reference information as you care to give. A copy of the applicant's written authorization is attached. We will not ask, nor do we seek, confidential information concerning financial and/or health related issues of the employee while employed by your company. Any information we obtain will be kept confidential to the extent possible, and is not intended to be released to the candidate. Further, the information we obtain during the interview will not be the sole determining factor used in our final decision.

Please complete the form below and/or call us at your earliest convenience to discuss this applicant. Thank you.

Please indicate whether the information stated is correct by checking the "Yes" or "No" box as appropriate. If this information is not correct, please provide the correct information in the space provided, or attach additional notes, as necessary.

**Dates of Employment: Correct?**  Yes  No Corrections (if required)

**Position Held: Correct?**  Yes  No Corrections (if required)

**Last Rate of Pay: Correct?**  Yes  No Corrections (if required)

**Reason for Leaving: Correct?**  Yes  No Corrections (if required)

**Is this individual eligible for rehire with your company?**  Yes  No

Please use the following space to provide any other information you care to release. We appreciate your providing any information that would be helpful in making a hiring decision.

**Your Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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