



# BERMUDA NURSING COUNCIL

MINISTRY OF HEALTH & SOCIAL SERVICES  
 P.O. Box HM 674, Hamilton HM CX, Bermuda  
 Telephone: (441) 236-0224 Ext. 3409  
 Fax: (441) 232-1823

## STANDARD PROFESSIONAL REFERENCE CHECK

Date.....

To: (Name of Person Giving Reference).....

Address:.....

Telephone Number..... Fax Number.....

The Applicant named below has informed us that he/she previously worked for you. We would appreciate your furnishing us with as much of the information requested below as possible. We assure you that any information you may give will be treated confidentially.

Please note that this reference MUST NOT under any circumstance be given back to the applicant. Please mail directly back to the Bermuda Nursing Council.

An immediate reply will be greatly appreciated.

Sincerely yours,  
 BERMUDA NURSING COUNCIL

.....  
 Corinne Swan, Secretary/Administrator

APPLICANT'S NAME.....

DATES IN YOUR EMPLOY: FROM..... TO.....

POSITION HELD:.....

WHY DID APPLICANT LEAVE?.....

WOULD YOU RE-EMPLOY ? YES..... NO..... IF NO, WHY NOT?.....

|                     | POOR | FAIR | AVERAGE | VERY GOOD | EXCELLENT |
|---------------------|------|------|---------|-----------|-----------|
| QUALITY OF WORK     |      |      |         |           |           |
| QUANTITY OF WORK    |      |      |         |           |           |
| PERSONALITY         |      |      |         |           |           |
| PERSONAL APPEARANCE |      |      |         |           |           |
| ATTENDANCE          |      |      |         |           |           |
| DEPENDABILITY       |      |      |         |           |           |
| COOPERATIVENESS     |      |      |         |           |           |
| CREATIVENESS        |      |      |         |           |           |
| HEALTH              |      |      |         |           |           |

