

# NURSE MANAGEMENT SERVICES OF GEORGIA, INC.

## EMPLOYMENT REFERENCES

DATE: \_\_\_\_\_

Dear \_\_\_\_\_: Of \_\_\_\_\_

The importance of checking references on personnel working in a life/death situation cannot be overemphasized. The applicant whose signature appears below has given you as a source of reference. May we count on your assistance in substantiating the qualifications of our applicants? You can count on our strict confidence in handling any information you may want to let us have. For your convenience, a return stamp has been provided. Thank you in advance for your courtesy and understanding.

\_\_\_\_\_  
Branch Representative

**Applicant: Please fill out shaded areas only.**

**Applicant:** \_\_\_\_\_ **Soc. Sec. #** \_\_\_\_\_

**Position Held:** \_\_\_\_\_ **Dates Employed: From** \_\_\_\_\_ **To:** \_\_\_\_\_

**I hereby authorize the following information be released to Nurse Mgmt Services of GA, Inc.**

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

Do the above employment dates correspond to your records?

YES

NO

Does the above position correspond to your records?

YES

NO

Subject to rehire?

YES

NO

If no, why not?

\_\_\_\_\_  
\_\_\_\_\_

Any comments on this applicant: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

General Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature** \_\_\_\_\_ **Position** \_\_\_\_\_ **Date** \_\_\_\_\_

Relationship to applicant

\_\_\_\_\_

If verified by telephone: Contact Name \_\_\_\_\_ Position \_\_\_\_\_ Date \_\_\_\_\_

Please send me information on Nurse Mgmt Services of GA, Inc.

If responding by mail send to: Attn: Human Resources P.O. Box 688 Hampton, Georgia 30228.

If responding by fax send to Attn: Human Resources (770) 991-6972

(Nurses and allied health personnel available locally and on traveling contracts to help meet your staffing requirements).

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## CHAMBLEE POLICE DEPARTMENT

R Marc Johnson  
CHIEF OF POLICE

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A State Certified Law Enforcement Agency

### CHAMBLEE POLICE DEPARTMENT CRIMINAL HISTORY CONSENT FORM

I hereby authorized Nurse Management Services of Georgia, Inc.  
to receive any Georgia criminal history record information pertaining to me which may be in the files of any state or any local criminal justice agency in Georgia.

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Full Name (Printed)

---

Address

---

Sex

---

Race

---

Date of Birth

---

Social Security Number

---

Signature

---

Date

---

Special employment provisions (check if applicable)

- Employment with medically disabled (Purpose code 'M')
- Employment with elderly care (Purpose code 'N')
- Employment with children (Purpose code 'W')

**One of the following must be checked:**

- This authorization is valid for 90 /180 \_\_\_\_\_ ( circle one ) days from the date of signature
- I, \_\_\_\_\_ give my consent to the above  
Named to perform periodic criminal history background checks for the duration of my employment with this company.