

**AUTHORIZATION FOR
RELEASE OF
EMPLOYMENT INFORMATION**

Please complete and return by **December 4, 2009** to address listed below or via fax to 320-656-7022

Name: _____

If employed under another name please list here: _____

Social Security Number: _____

I hereby authorize St. Cloud Hospital to contact the employers, schools and references, which I have provided. I give my permission for you to release any information St. Cloud Hospital deems necessary for the purpose of evaluating me for possible employment. I hereby release such employers, schools and references from any and all liability for the furnishing of such information.

Date: _____ Signature: _____

WE WOULD APPRECIATE YOUR EVALUATION OF THIS PERSON

| <u>Evaluation</u> | Above Average | Average | Below Average |
|-------------------------------|---------------|---------|---------------|
| Responsibility | _____ | _____ | _____ |
| Quality of Work | _____ | _____ | _____ |
| Dependability | _____ | _____ | _____ |
| Job Performance | _____ | _____ | _____ |
| Attendance | _____ | _____ | _____ |
| Knowledge of Technical Skills | _____ | _____ | _____ |
| Patient/Coworker relations | _____ | _____ | _____ |

Additional comments: _____

Evaluation information from: Personal knowledge _____ File material _____

Person furnishing information: _____

Title: _____ Telephone# _____

Employer: _____

St. Cloud Hospital, Human Resources
 1406 Sixth Avenue North, St. Cloud, Minnesota 56303-1901, Fax 320-656-7022, Phone 800-835-6608
 St. Cloud Hospital operates under the auspices of the local Catholic church of St. Cloud