Company Logo

NURSING AGENCY REFERENCE REQUEST FORM

Agency Name	
Address	
Phone	
Email	
Date	____ / ____ / _____
Applicant Details	
Applicant Name	
Position Applied For	
Date of Birth	
PPS Number (optional)	
Employment Dates with Referee Organisation	From _____ To _____
Referee Details	
Referee Name	
Referee Position	
Organisation	
Contact Number	
Email	
Employment Verification	
1. Was the applicant employed?	Yes / No
2. Job title held	
3. Dates of employment	
4. Type of employment	Full-time / Part-time / Agency / Contract / Other
5. Reason for leaving	
6. Would you re-employ?	Yes / No / Unsure
Professional Conduct	
7. Reliability and punctuality	Excellent / Good / Fair / Poor
8. Clinical skills	Excellent / Good / Fair / Poor
9. Teamwork	Yes / No

10. Followed safeguarding procedures	Yes / No
11. Disciplinary issues	
12. Concerns (patient care/behaviour)	
13. Suitable for vulnerable groups	Yes / No
Declaration	
I confirm that the information provided is accurate to the best of my knowledge.	
Referee Name	
Signature	
Date	____ / ____ / _____
Information provided will be used solely for recruitment and compliance purposes in accordance with Irish GDPR regulations.	