

Ohio Department of Medicaid  
**REFERENCE CHECK**

We are considering the applicant listed below for a position with the Ohio Department of Medicaid. The applicant has provided your name as a former/current employer. Information obtained below will be utilized for verification of employment and reference check purposes and will be kept in strict confidence as allowed by Ohio Revised code 4113.71, (Immunity of employer as to job performance information disclosures).

Name of Applicant	Maiden/Other	Position
Name of Employer Contacted		Dates of Employment
Address of Employer Contacted		Job Title
Phone Number of Employer Contacted		Duties Performed

**PERFORMANCE CRITERIA** (check one for each criteria listed)

	Excellent	Average	Poor	Comments (If additional space is needed, attach a sheet)
Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dependability/Work Ethic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Performance of Job Duties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Quality/Quantity of Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Team Player/Cooperation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Was employee ever disciplined while under your employment?     Yes     No

If YES, please explain:

Why did employee leave your employment?

Would you rehire?     Yes     No

If NO, please explain:

***If applying for a Supervisory/Management position please answer the following:***

How would you describe the applicant's ability to motivate and develop subordinates?

Any additional comments relating to this potential employee for Medicaid?

Signature of Person Completing Reference Check	Date
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**"I give my permission to the party listed above to fully respond to the inquiries of the Ohio Department of Medicaid"**

Applicant's Signature	Date
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