

REFERENCES

Name	Relationship	Phone Number
1		
2		
3		

I authorize the references listed above to give you all information concerning my employment with them, and pertinent information they may have, personal or otherwise. **Further, I release all parties from liability for any damage that may result from furnishing such information to you.**

Applicant Signature: _____ Date: _____

EQUAL EMPLOYMENT OPPORTUNITY

Outreach Health Services is committed to providing equal opportunity to all qualified employees and applicants for employment. No employee or applicant will be discriminated against on the basis of race, color, religion, gender, national origin, age, ancestry, veteran status, marital status, disability and other factors prohibited by state and federal laws.

AUTHORIZATION FOR RELEASE OF INFORMATION

To Whom it May Concern:

I hereby authorize and request any present or former employer, school, police department, financial institution or other person having personal knowledge about me, to furnish bearer with any and all information in their possession regarding me in connection with an application for employment. A photocopy of this authorization may be accepted with the same authority as the original, and I specifically waive any written notice from any present or former employer who may provide information based upon this authorized request. I understand this authorization is to be part of the written application that I sign.

Printed Name: _____

Applicant Signature: _____ Date: _____

APPLICATION CERTIFICATION & ACKNOWLEDGMENTS

I certify that all information given is true and complete, and that I have accounted for all work experience and training for the last 10 years. I understand that misrepresentation or omission of information may cause for cancellation of my consideration for employment or termination, if already employed, and that employment may also be contingent upon my ability to perform specific job-related duties, with or without accommodation. I further understand that this is an employment "at will" application, and that no employment contract is being offered. If employed, such employment is for an indefinite period of time and is subject to changes in wages, conditions, benefits, and operating requirements. I further acknowledge that employment is contingent on I-9 verification of eligibility of employment. I understand that Outreach Health Services is a voluntary non-subscriber to Workers Compensation in Texas.

Applicant Signature: _____ Date: _____

FOR OFFICIAL USE ONLY – Social Security #(when available) _____

OFFICE LOCATION: _____ DATE INTERVIEWED: _____

DATE APPLICATION RECEIVED: _____ INTERVIEWED BY: _____

APPLICATION RECEIVED BY: _____ SIGNATURE: _____

SIGNATURE: _____ DATE HIRED: _____