Candidate Authorization Release

Upon completion of the form, please fax to 636-891-9784 or save form and attach to an email to: info@toberson.com

I voluntarily consent to authorize The Toberson Group or any of its officers, employees, agents, or clients to check my references by contacting any person or entity whom they deem to be an appropriate reference. I understand that questions may be asked about my educational background, work experience, achievements, wage history, performance, attendance, personal history, character, personality, disciplinary information, and reason for separation from former employment.

It is expressly understood that any information given is to be used for the purpose of determining my acceptability for employment with one of The Toberson Group's clients.

I also hereby release The Toberson Group from all liability for damages or claims, including but not limited to, defamation, interference with contract, and negligence, which may arise or result from any reference information gathered pursuant to this authorization.

_____ _____

Candidate's Signature Date

_____ _____ _____

Printed Name Date of Birth SSN

DEMOGRAPHICS

Medical School:	Year of Graduation:

Current Practice Name:	Street Address:		
	City:	State:	Zip:

PEER REFERENCES

List three clinical references including your program director if residency or fellowship completion was within the last five years. Include department chair from previous facility if residency or fellowship were completed greater than five years. **Emails are necessary, lack of email accuracy will delay interview process.**

Name:	Institution:	Email:
Title:		Phone:
		Fax:

Name:	Institution:	Email:
Title:		Phone:
		Fax:

Name:	Institution:	Email:

Title:		Phone:
		Fax

Return completed form to: fax 636-891-9784 or save completed form and attach to an email to: info@toberson.com