



Referral Bonus Program

REFERRAL SUBMISSION FORM

Associate # _____

Eligibility contingent upon either:

Form must be received PRIOR to the candidate's start date, or Referrer's name must be on application

Date: _____

Individual Making Referral: _____

Affiliation to CHS: Associate Family Member Retiree Physician Vendor Other _____
(circle one) (please indicate)

Home Address: _____ City: _____

Address Line 2: _____ State, Zip: _____

If not an associate, you must provide your Social Security Number to receive payment: _____ E Mail Address: _____

Telephone Number: _____ Alternate Telephone: _____

1. Name of the person you are Referring: _____

2. Eligible position you are Referring to: _____

3. His/her Telephone Number: _____ E Mail Address: _____

4. Is s/he a new graduate? YES NO

5. Does s/he have a preference for work?

Hospital Long Term Care Home Care Do not know

Please Mail this form to: Catholic Health HR,
Appletree Business Park Suites 1-3, Cheektowaga, New York 14227
Or, fax form to (716) 706-2595

By signing this form, I agree that both the referred candidate and I will be contacted. I understand that submission of this form does not guarantee referral bonus payment.

Signature of Person Making Referral _____ Date _____

DO NOT WRITE IN THE BOX BELOW

Date Rec'd in HR: _____	Referral Number: _____
Reviewed and Logged: YES <input type="checkbox"/> NO <input type="checkbox"/>	Approved: YES <input type="checkbox"/> NO <input type="checkbox"/>
Referred to Recruiter: YES <input type="checkbox"/> NO <input type="checkbox"/> Name: _____	
	Dollar Amount Eligible For: _____
Referral Hired: YES <input type="checkbox"/> NO <input type="checkbox"/>	Facility: _____
Position: _____	Shift/Status: _____
Start Date: _____	Signature: _____