



### 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: \_\_\_\_\_

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 SHADED SECTION 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: _____	
Referral Hired: YES <input type="checkbox"/> NO <input type="checkbox"/>	Facility: _____
Position: _____	Shift/Status: _____
Start Date: _____	Signature: _____