



**Home Care Provider PERSONAL REFERENCE QUESTIONNAIRE**

*This reference is required by Bermuda Health Council for home care provider applications. It is to be completed by the person providing the reference, not the applicant. Rate the applicant based on your experience and interactions.*

**Your Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_

**Name of Applicant** (person you are providing a reference for): \_\_\_\_\_

1. How do you know the applicant?  Friend  Acquaintance  Former Employer  
 Neighbor  Care Recipient  Other \_\_\_\_\_
2. How long have you known the applicant? \_\_\_\_\_
3. When was the last time you had contact with the applicant? \_\_\_\_\_

*Respond to all questions by checking which response best describes your experience with this applicant.*

	<b>Strongly agree</b>	<b>Agree</b>	<b>Neutral</b>	<b>Disagree</b>	<b>Strongly disagree</b>
4. Applicant gets along well with others.					
5. Applicant handles stressful situations well.					
6. I have trust the applicant would keep private information confidential.					
7. I believe the applicant is honest and trustworthy.					
8. I have not witnessed any displays of prejudice.					
9. The applicant loses his/her temper easily.					
10. I do not have any knowledge of the applicant's use or involvement with illegal drugs or narcotics.					
11. I believe the applicant is reliable.					
12. I would recommend the applicant as a caregiver.					

**COMMENTS:**

Signature \_\_\_\_\_

Date \_\_\_\_\_