

**Salon Tuscany Inc.**  
108 W. Broadway, Derry NH 03038  
603.425.1033

## APPLICATION FOR EMPLOYMENT

### **PERSONAL INFORMATION:**

First and Last Name: \_\_\_\_\_ Date: \_\_\_\_\_

Present Address: \_\_\_\_\_ City: \_\_\_\_\_ State & Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Referred By: \_\_\_\_\_

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Date You Can Start: \_\_\_\_\_ Salary Desired: \_\_\_\_\_

Position That You Are Applying For: *(Please Check All That Apply)*

\_\_\_ Stylist            \_\_\_ Massage Therapist            \_\_\_ Esthetician  
\_\_\_ Nail Tech        \_\_\_ Receptionist                    \_\_\_ Other: please specify \_\_\_\_\_

### **EDUCATION HISTORY:**

<i>Name &amp; Location of School</i>	<i>Diploma: (Y/N)</i>	<i>Year of Grad</i>
High School: _____	_____	_____
College: _____	_____	_____
Tech College: _____	_____	_____

**EMPLOYMENT HISTORY:**

Are You Currently Employed: \_\_\_\_\_ May We Inquire Of Your Employer? \_\_\_\_\_

Former Employers:

<i>Date: Month &amp; Year</i>	<i>Name &amp; Address of Employer</i>	<i>Salary</i>	<i>Position</i>	<i>Reason for Leaving</i>
From: To:				
From: To:				
From: To:				
From: To:				
From: To:				

**AUTHORIZATION:**

“I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal.

I authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information.

I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by a company representative.

This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the Americans with Disabilities Act (ADA) and other relevant federal and state laws.”

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Interviewed by: \_\_\_\_\_ Date: \_\_\_\_\_