

CONNECTICUT HEALTH FACILITIES

APPLICATION FOR EMPLOYMENT

FEDERAL AND STATE LAW PROHIBITS DISCRIMINATION BECAUSE OF SEX, RACE, COLOR, RELIGIOUS CREED, AGE, NATIONAL ORIGIN, MARITAL STATUS, MENTAL OR PHYSICAL DISABILITY, INCLUDING BUT NOT LIMITED TO BLINDNESS.

NAME: _____ DATE: _____

PRESENT ADDRESS: _____
 STREET NUMBER & ADDRESS

CITY _____ STATE _____ ZIP CODE _____

SOCIAL SECURITY NUMBER: _____

PHONE # H () _____ # W () _____

ARE YOU OVER THE MINIMUM LEGAL WORKING AGE? _____ YES _____ NO

POSITION APPLYING FOR: _____ RATE OF PAY EXPECTED: _____

NUMBER OF HOURS DESIRED: _____ FULL TIME: _____ PART TIME: _____

SHIFT(S) AVAILABLE TO WORK: _____

NURSES: RN _____ LPN _____ OTHER _____ CT LICENSE No. _____

MA LICENSE No. _____

NURSES AIDES:

CERTIFIED _____ YES _____ NO WHERE TRAINED: _____

REGISTERED _____ YES _____ NO IF YES, REGISTRATION # _____

OTHER: _____

EMPLOYMENT HISTORY (LIST IN ORDER: PRESENT TO LAST EMPLOYMENT)

DATE	WORKED	NAME & ADDRESS	FORMER	FORMER	REASON FOR
FROM	TO	PHONE # OF EMPLOYER	POSITION	TITLE	LEAVING

MAY WE CONTACT THE EMPLOYERS LISTED? _____ IF NOT, INDICATE THE ONE(S) YOU WISH US TO CONTACT:

IF YOU HAVE WORKED UNDER A DIFFERENT NAME AT ANY OF THE JOB(S) LISTED, PLEASE INDICATE THE DIFFERENT NAME AND WHEN USED: _____

ONLY IF YOU HAVE NOT WORKED BEFORE, PLEASE SUPPLY US WITH TWO PERSONAL REFERENCES (NOT RELATIVES).

NAME	ADDRESS	TELEPHONE #	OCCUPATION

LIST OTHER QUALIFICATIONS (SKILLS, TRAINING, EXPERIENCES, ETC.,) NOT LISTED ELSEWHERE ON THIS FORM WHICH WOULD ESPECIALLY FIT YOU FOR WORK WITH THIS COMPANY:

ADDITIONAL COMMENTS WHICH YOU FEEL WOULD BE IMPORTANT IN OUR CONSIDERATION OF YOUR APPLICATION:

IF HIRED, DO YOU HAVE A RELIABLE MEANS OF TRANSPORTATION: _____

HOW DID YOU LEARN OF THIS FACILITY? _____

EDUCATIONAL BACKGROUND

TYPE OF SCHOOL	NAME & ADDRESS	YEARS ATTENDED	MAJOR
GRAMMAR/GRADE SCHOOL			
HIGH SCHOOL			
COLLEGE			
POST GRADUATE			
BUSINESS/TRADE			

LEGAL RIGHT TO WORK IN THE U.S.

ARE YOU ABLE, AT THE TIME OF EMPLOYMENT, TO SUBMIT VERIFICATION OF YOUR LEGAL RIGHT TO WORK IN THE UNITED STATES: Yes_____ No _____

OTHER CRITERIA FOR EVALUATING SUITABILITY FOR EMPLOYMENT

CONVICTIONS/DISCIPLINARY ACTION FROM LICENSING AGENCY:

CONNECTICUT PUBLIC ACT NO. 84-350 REQUIRE THAT MOST NURSING HOME EMPLOYEES MUST COMPLETELY ANSWER THE FOLLOWING QUESTIONS (1 & 2). OUR FACILITY REQUIRES ALL PROSPECTIVE EMPLOYEES MUST COMPLETELY ANSWER THESE QUESTIONS:

- 1. HAVE YOU EVER BEEN CONVICTED OF (1) A FELONY, (2) CRUELTY TO PERSONS, OR (3) ASSAULT OF A VICTIM SIXTY YEARS OF AGE OR OLDER? IF SO, PLEASE DESCRIBE THE DATE OF THE CONVICTION AND THE UNDERLYING CIRCUMSTANCES OR OTHER INFORMATION TO HELP US EVALUATE YOUR CURRENT FITNESS FOR EMPLOYMENT.

_____No _____ Yes (IF SO, ANSWER ALL QUESTIONS ASKED IN #1 ABOVE).

- 2. HAVE YOU EVER BEEN SUBJECT TO DISCIPLINARY ACTION BY A LICENSING AGENCY IN ANY STATE, THE DISTRICT OF COLUMBIA, A UNITED STATES POSSESSION OR TERRITORY, OR A FOREIGN JURISDICTION? IF SO, PLEASE IDENTIFY THE NATURE AND DATE OF THE ACTION, THE LICENSING AGENCY INVOLVED, AND THE UNDERLYING CIRCUMSTANCES OR OTHER INFORMATION TO HELP US EVALUATE YOUR CURRENT FITNESS FOR EMPLOYMENT.

_____No _____ Yes (IF SO, ANSWER ALL QUESTIONS ASKED IN #2 ABOVE).

LIMITATIONS OR DISABILITIES

- 1. ARE YOU FULLY ABLE TO PERFORM THE DUTIES OF THE JOB FOR WHICH YOU HAVE APPLIED FOR WITHOUT ENDANGERING YOURSELF, OTHER EMPLOYEES OR RESIDENTS?

_____No _____ Yes (IF SO, ANSWER ALL QUESTIONS ASKED IN #2 ABOVE).

2. IF NO, PLEASE DESCRIBE ANY TASKS WHICH YOU ARE NOT ABLE TO PERFORM AND WHAT ACCOMMODATION IS NECESSARY TO ENABLE YOU TO PERFORM SUCH TASK.

I AGREE TO TAKE A PHYSICAL EXAMINATION AT THE FACILITY'S REQUEST AT ANY TIME AFTER I AM OFFERED A POSITION. I ALSO AGREE THAT THE EXAMINING PHYSICIAN MAY DISCLOSE THE FINDINGS OF THE EXAMINATION TO THE FACILITY OR ITS AUTHORIZED AGENT. FURTHER, I AGREE TO RELEASE AND HOLD HARMLESS THE FACILITY, ITS OFFICERS, AGENTS AND EMPLOYEES FROM ANY LIABILITY BASED UPON THE REQUEST FOR ADMINISTRATION OF AND USE OF THE RESULTS OF ANY PHYSICAL EXAMINATION.

* PHYSICALS ARE COMPLETED BY INDUSTRIAL HEALTH CARE, CHF 'S MEDICAL PROVIDER, AT THE EMPLOYEES COST OF \$58.00.

VERIFICATION OF FACTS STATED APPLICANT IN THE APPLICATION

I THEREBY CERTIFY THAT THE FACTS SET FORTH IN THE ABOVE EMPLOYMENT APPLICATION BE TRUE AND COMPLETE. I UNDERSTAND THAT FALSIFICATION OR ELIMINATION OF FACTS WILL JEOPARDIZE HIRING OR CONSTITUTE CAUSE FOR DISMISSAL. I ALSO UNDERSTAND THAT EMPLOYMENT WILL BE ON AN EMPLOYMENT-AT-WILL STATUS. I UNDERSTAND MY EMPLOYMENT CAN BE TERMINATED ANY TIME AND FOR ANY REASON BY EITHER THE FACILITY OR BY MYSELF. IF HIRED, I WILL ABIDE BY ALL RULES AND REGULATIONS, HOWEVER, I UNDERSTAND THAT SUCH RULES MAY BE CHANGED AT ANY TIME BY THE FACILITY AS NECESSARY.

DATE _____ SIGNATURE OF APPLICANT _____



THANK YOU FOR COMPLETING THIS APPLICATION AND FOR HAVING AN INTEREST IN EMPLOYMENT WITH US. IF THERE IS NOT A CURRENT OPENING FOR THE POSITION YOU HAVE APPLIED FOR, YOUR APPLICATION WILL BE KEPT ON FILE FOR 30 DAYS IN CASE OF AN OPENING. AFTER THAT, POSITION MUST BE RE-APPLIED FOR.



IN COMPLIANCE WITH THE CIVIL RIGHTS ACT OF 1964, TITLE VI, AND OTHER STATE AND FEDERAL LAWS, THIS FACILITY WILL BE FAIR AND IMPARTIAL IN RELATIONS WITH PERSONNEL AND APPLICANTS FOR EMPLOYMENT – BE IT RECRUITING, DISCHARGING, TRANSFERRING, TRAINING, LAYOFF, COMPENSATION OR TERMS, CONDITIONS OR PRIVILEGES OF EMPLOYMENT BENEFITS – WITHOUT REGARD TO RACE, COLOR, RELIGIOUS CREED, AGE, SEX, MARITAL STATUS, NATIONAL ORIGIN, MENTAL OR PHYSICAL DISABILITY, INCLUDING BOTH NOT LIMITED TO BLINDNESS.

CONNECTICUT HEALTH FACILITIES
APPLICANT’S AUTHORIZATION TO RELEASE INFORMATION

I GIVE MY PERMISSION TO THE SUFFIELD HOUSE TO MAKE INQUIRES TO MY CURRENT AND FORMER EMPLOYERS AS NOTED BY MY CHECK OF A OR B BELOW:

- _____ A. AT THIS TIME, MY CURRENT AND FORMER EMPLOYERS MAY BE CONTACTED
- _____ B. AT THIS TIME, JUST MY FORMER EMPLOYERS SHOULD BE CONTACTED.
- _____ ONCE, HOWEVER, A NEW JOB HAS BEEN OFFERED TO ME AND/OR I HAVE LEFT MAY CURRENT EMPLOYMENT CHF MAY AT THAT TIME CONTACT SUCH EMPLOYER.

I ALSO GIVE PERMISSION TO THE SUFFIELD HOUSE TO MAKE INQUIRIES TO LICENSING OR REGISTRATION AUTHORITIES (WITH RESPECT TO THE CURRENT STATUS, ETC., OF MY PROFESSIONAL LICENSE) AND TO ANY OTHER PARTY TO VERIFY OTHER REPRESENTATIONS I HAVE MADE IN MY EMPLOYMENT APPLICATION, RESUME, OR DURING ANY INTERVIEWS.

I AGREE NOT TO HOLD ANYONE LIABLE FOR SUCH INQUIRIES REGARDING MY EXPERIENCE, CHARACTER, AND THE REASON FOR LEAVING ANY AND ALL PASS EMPLOYMENT.

I UNDERSTAND THAT MY FAILURE TO GIVE CORRECT AND COMPLETE INFORMATION ON MY EMPLOYMENT APPLICATION, RESUME, OR DURING PERSONAL INTERVIEWS WILL BE CONSIDERED GROUNDS FOR DISMISSAL UPON DISCOVERY THEREOF.

NAME _____ DATE _____
(PLEASE PRINT)

SIGNATURE _____

ORIGINAL TO BE KEPT IN EMPLOYEE FILE OR WITH APPLICATION BEFORE HIRE. COPY OF THIS AUTHORIZATION SENT WITH REFERENCE CHECK.

EMPLOYMENT APPLICATION