



EMPLOYMENT / JOB APPLICATION

PERSONAL INFORMATION

FULL NAME: _____ **DATE:** _____
First Middle Last

ADDRESS: _____
Street Address Apt/Suite

City State Zip Code

E-MAIL: _____ **PHONE:** _____

SOCIAL SECURITY NUMBER (SSN): _____ - _____ - _____

DATE AVAILABLE: _____ **DESIRED PAY:** \$ _____ HOUR SALARY

POSITION APPLIED FOR: _____

EMPLOYMENT DESIRED: FULL-TIME PART-TIME SEASONAL

EMPLOYMENT ELIGIBILITY

ARE YOU LEGALLY ELIGIBLE TO WORK IN THE U.S.? YES NO*

HAVE YOU EVER WORKED FOR THIS EMPLOYER? YES* NO

***IF YES, WRITE THE START AND END DATES:** _____

HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES* NO

***IF YES, PLEASE EXPLAIN:** _____

EDUCATION

HIGH SCHOOL: _____ **CITY / STATE:** _____

FROM: _____ **TO:** _____

GRADUATE? YES NO **DIPLOMA:** _____

COLLEGE: _____ **CITY / STATE:** _____

FROM: _____ **TO:** _____

GRADUATE? YES NO DEGREE: _____

OTHER: _____ CITY / STATE: _____

FROM: _____ TO: _____

DEGREE/CERTIFICATION: _____

OTHER: _____ CITY / STATE: _____

FROM: _____ TO: _____

DEGREE/CERTIFICATION: _____

RECENT PREVIOUS EMPLOYMENT

EMPLOYER 1: _____
Company / Individual

E-MAIL: _____ PHONE: _____

ADDRESS: _____
Street Address Apt/Suite

_____ City State Zip Code

JOB TITLE: _____ RESPONSIBILITIES: _____

FROM: _____ TO: _____

REASON FOR LEAVING: _____

EMPLOYER 2: _____
Company / Individual

E-MAIL: _____ PHONE: _____

ADDRESS: _____
Street Address Apt/Suite

_____ City State Zip Code

JOB TITLE: _____ RESPONSIBILITIES: _____

FROM: _____ TO: _____

REASON FOR LEAVING: _____

EMPLOYER 3: _____
Company / Individual

E-MAIL: _____ PHONE: _____

ADDRESS: _____
Street Address Apt/Suite

City State Zip Code

JOB TITLE: _____ RESPONSIBILITIES: _____

FROM: _____ TO: _____

REASON FOR LEAVING: _____

REFERENCES
(PROFESSIONAL ONLY)

FULL NAME: _____ RELATIONSHIP: _____
First Last

COMPANY: _____ TITLE: _____

E-MAIL: _____ PHONE: _____

FULL NAME: _____ RELATIONSHIP: _____
First Last

COMPANY: _____ TITLE: _____

E-MAIL: _____ PHONE: _____

FULL NAME: _____ RELATIONSHIP: _____
First Last

COMPANY: _____ TITLE: _____

E-MAIL: _____ PHONE: _____

MILITARY SERVICE

ARE YOU A VETERAN? YES NO

BRANCH: _____ RANK AT DISCHARGE: _____

FROM: _____ TO: _____

TYPE OF DISCHARGE: _____

IF NOT HONORABLE, PLEASE EXPLAIN: _____

LICENSES/CERTIFICATIONS/SKILLS

PLEASE LIST ALL CURRENTLY HELD LICENSES AND CERTIFICATIONS:

DO YOU KNOW A FOREIGN LANGUAGE? YES* NO

***IF YES, PLEASE FILL OUT BELOW:**

LANGUAGE	SPEAK	READ	WRITE
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LIST ANY SPECIAL SKILLS AND/OR TRAINING THAT YOU HAVE AND USE THE RATINGS BELOW TO ASSESS YOUR PROFICIENCY LEVEL.

1=Excellent 2=Good 3=Average 4=Marginal

SKILL:	RATING:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

BACKGROUND CHECK CONSENT

IF ASKED, ARE YOU WILLING TO CONSENT TO A BACKGROUND CHECK? YES NO

AVAILABILITY

Please answer with YES, NO, or ON CALL.

Saturday:	Day Hours (7a-3p):
Sunday:	Evening Hours (3p-11p):
Weekdays:	Night Hours (11p-7a):
Holidays:	OT:

DISCLAIMER

Applicant understands that this is an Equal Opportunity Employer and committed to excellence through diversity. In order to ensure this application is acceptable, please print or type with the application being fully completed in order for it to be considered.

Please complete each section EVEN IF you decide to attach a resume.

I, the Applicant, certify that my answers are true and honest to the best of my knowledge. If this application leads to my eventual employment, I understand that any false or misleading information in my application or interview may result in my employment being terminated.

I understand that, if I am hired, my employment will be at will, meaning that either I or the employer may discontinue my employment at any time, with or without cause, and that my employment may be subject to the terms of an employee handbook or other policies. I further understand that my employment may be conditioned on a satisfactory medical examination and/or drug screen. In consideration of the employer's review of this application, I release the employer and all prior employers from any liability relating to investigation of my prior employment.

SIGNATURE _____ **DATE** _____

PRINT NAME _____



BCI Registration Information

All prospective employees should fill out this form during an in-person interview.

Last Name: _____

First Name: _____

Middle Name: _____
(as shown on driver's license)

Date of Birth: _____

Place of Birth: _____
(state you were born in)

Social Security #: _____

Biological Sex: _____

Race: _____

Eye Color: _____

Hair Color: _____

Height: _____

Weight: _____

Country of Citizenship: _____

Driver's License Number: _____

Driver's License State: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____
(specify home or cell)

E-Mail address: _____



MEDICAL REQUIREMENTS PRIOR TO BEGINNING EMPLOYMENT

The following are required for all employees at Woonsocket Health & Rehabilitation Centre prior to initiation of employment:

1. You are required to have a physical examination done by a physician, dated no more than one year to your start date. This exam should indicate that you have no work restriction upon hire.
2. You will be required to have a PPD (Tuberculin Skin Test) with a negative result prior to resident contact. Testing is free and is provided by the facility. A second PPD test will be done at least one week later. A positive PPD (>10mm) will require the result of CXR showing no active disease (NAD) and medical clearance dated after CXR was taken. All employees with known positive PPD, History of treated TB infection, or on preventative treatment for latent TB also have TB Screening done by facility.
3. You are required to have evidence of immunity to Measles, Mumps, Rubella.
 - a. Documentation of 2 doses of MMR if born on or after 1/1/1957. The first dose of vaccine must have been administered on or after the first birthday. The second does must be administered at least 4 weeks after the first does; or
 - b. Documentation for an MMR booster if born on or before 12/31/1956: or
 - c. Serologic evidence of acquired immunity (blood titer) in the event of an outbreak any healthcare worker born prior to 1957 will need to receive 2 doses of MMR if not previously received regardless of documentation immunity.
4. You are required to have evidence of immunity to Varicella (chicken pox)
 - a. Two (2) doses of Varicella vaccine. The second dose of varicella vaccine must be administered at least 4 weeks after the first dose or:
 - b. Laboratory evidence of immunity or laboratory confirmation of disease or:
 - c. A healthcare provider diagnosis of varicella, or healthcare provider verification of history of varicella disease or:
 - d. History of herpes Zoster based on healthcare provider diagnosis.
5. Tetanus, Diphtheria, and Pertussis (T-DAP)
 - a. All healthcare workers are required to have documentation of having received a dose of T-DAP regardless of age or the interval since the last TD vaccine. The T-DAP is available at this facility at no cost to employees.
6. Proof of Identification / Citizenship -- *please provide:*
 - a. Driver's License or Picture ID
 - b. Social Security Card or Birth Certificate or Work Authorization/Alien Registration Card
 - c. Proof of licensure if applicable
 - d. Alzheimer's Certification