COUNTRYSIDE HEALTH CARE OF MILFORD
APPLICATION FOR EMPLOYMENT

Countryside Health Care of Milford (CHC) is an Equal Opportunity Employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, sexual orientation, national origin, age, disability, handicap, or veteran status.

PERSONAL DATA **Date:** _____/_____/_____

1. Name _____
   Last First Middle Initial
2. Social Security Number: _____-_____-_____
3. Street: _____
4. City, State, Zip: _____
5. Home Phone: _____ Cell Phone: _____ Email: _____
6. How were you referred to us?
   ☐ Newspaper Ad ☐ Walk In ☐ Employee _____
   Name of Employee
   ☐ School ☐ Agency _____ ☐ Other _____
   Name of Agency Specify Source
8. Are you legally authorized to work in the United States: ☐ Yes ☐ No
   Note: If you are hired you will be required to submit proof of legal right to work in the United States.
9. Are you over 16 years of age? ☐ Yes ☐ No

POSITION AVAILABILITY

1. Indicate the position for which you are applying: _____
2. Type of employment desired:
   ☐ Full Time ☐ Part Time ☐ Per Diem
3. Shift Desired: ☐ Day ☐ Evening ☐ Night
4. Salary/Hourly Rate Desired: _____
5. When can you start? _____
6. Have you worked for CHC before? ☐ Yes ☐ No
   If yes, specify dates and department _____
7. Have you ever applied with CHC before? ☐ Yes ☐ No
   If yes, specify dates and department _____

EMPLOYMENT HISTORY

1. List below the names of all your employers (you may list volunteer positions as well as paid positions, if you wish). List present employer or more recent employer first. You may use an additional sheet if necessary.

Employer Information **Name** **Address** **Telephone**	**Dates of Employment**	**Reason for Leaving**	**Title/Nature of Work**	**Name of Immediate Supervisor**	**(CHC use only)** **References checked by:** **Date references checked:** **Comments**

2. Are you employed now? ☐ Yes ☐ No If yes, may we inquire of your present employer? ☐ Yes ☐ No

3. Do you have any commitments to another employer which may affect your employment with us? ☐ Yes ☐ No If yes, please explain.

_____

_____

4. Are you subject to any restrictive covenants from prior employment such as agreements to protect confidential or proprietary information of agreements not to compete? ☐ Yes ☐ No If yes, please explain.

_____

_____

REFERENCES:

Provide the following information regarding three persons **to whom you are not related** and have known for longer than one year.

Name **Address** **Telephone**	**Relationship?**	**Years Known**	**(CHC use only)** **References checked by:** **Date references checked** **Comments**

EDUCATIONAL DATA:

Type of School	Name and Address	Major Course of Study	Graduated (Yes or No)	Degree
High School				
College				
College				
Graduate School				
Trade/Business School				
Other				

Subject of Special Study or Research Work: _____

MISCELLANEOUS:

1. Were you in the U.S. Armed Forces? ☐ Yes ☐ No

   a. If Yes, which Branch: ☐ Army ☐ Navy ☐ Marines ☐ Air Force ☐ Coast Guard

   b. Dates of Duty: From _____ To: _____

   c. Rank at Separation: _____ Type of Discharge: _____

   d. Briefly describe your primary duty: _____

Note: CHC does not discriminate on the basis of National Guard or Reserve Duty obligations.

2 Please list any other information you think would be helpful to us in considering you for employment, such as organizations, activities, accomplishments, computer skills, etc. Exclude all information indicative of age, sex, sexual orientation, race, color, religion, national origin, disability or handicap.

_____

_____

AGREEMENT: (PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY)

I certify that all information on this application and any other material provided by me is true and complete. I agree that falsified information, misrepresentations or omissions on this application, or any accompanying resume or other materials will disqualify me for consideration for employment and will be considered justification for dismissal whenever discovered.

Unless otherwise noted, I authorize Countryside Health Care of Milford or its agent to investigate and/or verify all information in this application, including contacting all persons, schools, current employer(s) (if applicable), previous employer(s) and other individuals or entities herein (and those named on the accompanying resume, if any). I hereby authorize my former employer(s) and other third parties named on this application to release information pertaining to my work record, habits, and performances. In doing so, I hereby release them and Countryside Health Care of Milford and its agents from all liability which may flow from the release of information.

I understand that if I am hired, my employment will be on an at-will basis, for no definite term. As such, I understand that I will enjoy the right to terminate my employment at any time, and that Countryside Health Care of Milford will similarly enjoy the right to terminate my employment, at any time, with or without cause. This status can only be modified by a written document setting forth such modification, signed by both me and an authorized representative of Countryside Health Care of Milford. I further acknowledge that I am expected to abide by all facility rules, regulations, and policies, written and unwritten, but that such rules, regulations and policies do not create a contract between Countryside Health Care of Milford and me or otherwise restrict the right of either party to terminate this relationship.

_____ _____

Date Signature

Note: It is unlawful in Massachusetts to require or administer a lie detector test as a condition of employment. An employer who violates this law shall be subject to criminal penalties and civil liability.

******* Fill out the "From" line; leave "To" section blank; Sign and Date *******

COUNTRYSIDE HEALTH CARE OF MILFORD
ONE COUNTRYSIDE DRIVE
MILFORD, MASSACHUSETTS 01757
TEL: (508) 473-0435

AUTHORIZATION TO RELEASE INFORMATION

From: _____

c/o Countryside Health Care of Milford
One Countryside Drive
Milford, MA 01757

To: _____

_____

_____

_____

I have applied for a position with Countryside Health Care of Milford. As part of my application, I have been requested to provide information concerning my background and qualifications. Therefore, I authorize the investigation of my past and present work, character, education, military experience, and my employment qualifications by Countryside Health Care of Milford.

The release in any manner of any and all information by you to Countryside Health Care of Milford indicated above is authorized whether such information is of record or not. I do hereby release all persons, agencies, firms, companies, etc., from any responsibility for damages resulting from their provisions of such information.

This authorization is valid for 90 days from the date of my signature below. Please keep this copy of my release for your files. Thank you for your cooperation.

_____ _____
Signature Date

~We Care ~

Revised October 2018

COUNTRYSIDE HEALTH CARE OF MILFORD

CNA REGISTRY CHECK

IT IS THE POLICY OF COUNTRYSIDE HEALTH CARE OF MILFORD TO COMPLETE CNA REGISTRY CHECK ON ALL CURRENT OR PROSPECTIVE EMPLOYEES.

Applicant: Please complete this section:

NAME: _____ **DATE:** _____

SOCIAL SECURITY NUMBER: _____

This section for Countryside Health Care of Milford staff use only:

☐ In Good Standing

☐ No Record on File

☐ Other (Please Explain): _____

_____

_____

Verified by:

_____ _____ _____

Name Title Date

~We Care ~

CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM

TO BE USED BY ORGANIZATIONS CONDUCTING CORI CHECKS FOR EMPLOYMENT, VOLUNTEER, SUBCONTRACTOR, LICENSING, AND HOUSING PURPOSES.

Countryside Health Care of Milford is registered under the provisions of M.G.L. c.6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective employees, subcontractors, volunteers, license applicants, current licensees, and applicants for the rental or lease of housing.

As a prospective or current employee, subcontractor, volunteer, license applicant, current licensee, or applicant for the rental or lease of housing, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to Countryside Health Care of Milford to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing Countryside Health Care of Milford with written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY: Countryside Health Care of Milford may conduct subsequent CORI checks within one year of the date this Form was signed by me provided, however, that Countryside Health Care of Milford must first provide me with written notice of this check.

"An applicant for employment with a record expunged pursuant to section 100F, section 100G, section 100H or section 100K of chapter 276 of the General Laws may answer 'no record' with respect to an inquiry herein relative to prior arrests, criminal court appearances or convictions. An applicant for employment with a record expunged pursuant to section 100F, section 100G, section 100H or section 100K of chapter 276 of the General Laws may answer 'no record' to an inquiry herein relative to prior arrests, criminal court appearances, juvenile court appearances, adjudications or convictions."

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

SIGNATURE _____ DATE _____

SUBJECT INFORMATION:

_____

Last Name First Name Middle Name Suffix

_____

Maiden Name (or other name(s) by which you have been known)

_____ _____

Date of Birth Place of Birth

Last Six Digits of Your Social Security Number: _____ - _____

Sex: ____ Height: _____ ft. _____in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

_____ _____

Mother's Last Name, First Name, Maiden Name Father's Last Name, First Name

Your Current Address:

_____

Street Number & Name City/Town State Zip

Your Former Address:

_____

Street Number & Name City/Town State Zip

****

For CHC use only:

The above information was verified by reviewing the following form(s) of government issued identification (include expiration date(s) if applicable):

_____

_____

VERIFIED BY: _____

Name of Verifying Employee (Please Print)

_____

Signature of Verifying Employee