

COMMUNITY HEALTHLINK, INC. EMPLOYMENT APPLICATION

Date _____

POSITION(S) applied for - list in order of preference:		
1. _____	2. _____	3. _____

PERSONAL

Last Name	First Name	Middle Initial	Maiden Name (If applicable)
Address (Number & Street, Apartment or Box No.)		City	State Zip
Home Phone	Work Phone	Cell/Mobile Phone	Best Way to Contact
E-mail Address			
Desired Type of Employment <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Temporary	Desired Shift 1 st (7am – 3pm) _____ 2 nd (3pm – 11pm) _____ 3 rd (11pm – 7am) _____ Varied (Any) _____	Are you eligible to work in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No Proof of citizenship or immigration status will be required upon employment.	Are you age 18 years or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been previously employed by Community Healthlink? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, list dates employed: From: _____ To: _____ Program(s): _____	
			Desired Salary

EDUCATION

School/Institution (City, State)	Did you Graduate?	Major/Area of Study	GPA	Degree / Date of Graduation
1. High School Name: _____ City, State: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently Enrolled			Degree: _____ Date of Graduation: _____
2. College/University Name: _____ City, State: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently Enrolled			Degree: _____ Date of Graduation: _____
3. Graduate School Name: _____ City, State: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently Enrolled			Degree: _____ Date of Graduation: _____
4. Business/Trade School Name: _____ City, State: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently Enrolled			Degree: _____ Date of Graduation: _____
5. Other Name: _____ City, State: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently Enrolled			Degree: _____ Date of Graduation: _____

WORK EXPERIENCE

Are you currently employed? Yes No
 If yes, may we contact your present employer? Yes No

Begin with present or most recent employer and list prior employers. You may include any verifiable work performed on a voluntary basis.

1. Name of Employer		Address		City		State	Zip Code
Dates Employed		Salary		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Temporary		Your Job Title	
From:	To:	Start:	End:				
Phone		Supervisor's Name			Supervisor's Title		
Describe Major Duties				Reason For Leaving			
2. Name of Employer		Address		City		State	Zip Code
Dates Employed		Salary		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Temporary		Your Job Title	
From:	To:	Start:	End:				
Phone		Supervisor's Name			Supervisor's Title		
Describe Major Duties				Reason For Leaving			
3. Name of Employer		Address		City		State	Zip Code
Dates Employed		Salary		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Temporary		Your Job Title	
From:	To:	Start:	End:				
Phone		Supervisor's Name			Supervisor's Title		
Describe Major Duties				Reason For Leaving			
4. Name of Employer		Address		City		State	Zip Code
Dates Employed		Salary		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Temporary		Your Job Title	
From:	To:	Start:	End:				
Phone		Supervisor's Name			Supervisor's Title		
Describe Major Duties				Reason For Leaving			

MILITARY SERVICE

Branch	Start Date	End Date	Highest Rank Attained	Duties

LICENSES/CERTIFICATIONS HELD (Please check all that apply)

PhD _____ PsyD _____ EdD _____ Other: _____	LICSW _____ LCSW _____ LMHC _____ LMFT _____ LADC – I _____ LADC – II _____ Other: _____	NP _____ RNCS _____ RN _____ LPN _____ CNA _____ EMT _____ Other: _____	PT _____ OT _____ SLP _____ ABA _____ Other: _____	CAGS _____ MAPS _____ CPR _____ Other: _____
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FOREIGN LANGUAGE PROFICIENCY

	LEVEL OF PROFICIENCY					
	ORAL			WRITTEN		
	Fluent	Good	Fair	Fluent	Good	Fair
SPANISH						
PORTUGUESE						
VIETNAMESE						
MANDARIN						
OTHER (please indicate)						

OTHER SKILLS/QUALIFICATIONS

Please list other job related skills and qualifications:

SUMMARY

In a brief statement, **in your own words**, please describe why you are an ideal candidate for the position(s) for which you are applying for at Community Healththink, Inc.

REFERENCES

REFERENCE 1	REFERENCE 2	REFERENCE 3
NAME:	NAME:	NAME:
TITLE:	TITLE:	TITLE:
COMPANY:	COMPANY:	COMPANY:
RELATIONSHIP TO APPLICANT:	RELATIONSHIP TO APPLICANT:	RELATIONSHIP TO APPLICANT:
PHONE:	PHONE:	PHONE:
EMAIL:	EMAIL:	EMAIL:

*** WE ARE AN EQUAL OPPORTUNITY AFFIRMATIVE ACTION EMPLOYER AND DO NOT DISCRIMINATE AGAINST ANY PERSON ON THE BASIS OF RACE RELIGION, , COLOR, NATIONAL ORIGIN, GENDER, AGE, , VETERAN STATUS, SEXUAL ORIENTATION, DISABILITY OR ANY OTHER CATEGORY PROTECTED BY LAW.**

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

A. I certify that all the information that I have provided on this application is true and complete to the best of my knowledge. Any misrepresentation or omission of any fact in my application, resume, or other materials, or during interviews, can be justification for refusal of employment, or, if employed, termination from employment.

I authorize and request that all of my present and former employers and those individuals I have listed as personal references furnish information about my employment record, including a statement of the reason for the termination of my employment, work performance, abilities, and other qualities pertinent to my qualifications for employment. I hereby release my present and former employers, those individuals I have listed as personal references and Community Healthlink from any and all liability for damages arising from furnishing the requested information. I understand that if I refuse to provide such authorization, my application for employment will not be considered.

I understand that this Application for Employment is not an offer of employment. I understand that nothing contained in this employment application creates a contract between Community Healthlink and myself for employment or any other benefit. No promises regarding employment have been made and I understand that no such promise or guarantee is binding upon Community Healthlink. I understand that if I am hired, I will be an employee "at will," meaning I am not hired for any definite length of time and either I or Community Healthlink can terminate my employment at any time for any or no reason.

Signature of Applicant

Date

CORI REQUEST FORM

COMMUNITY HEALTHLINK has been certified by the Criminal History Systems Board for access to all conviction and pending criminal case data.

As applicant/employee for the position of _____,
I understand that a record check will be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. I further understand and agree that periodic checks may be conducted during my employment at Community Healthlink, Inc. The information below is correct to the best of my knowledge.

Applicant / Employee Signature
(Unless otherwise preempted by law)

Date

APPLICANT/ EMPLOYEE INFORMATION (PLEASE PRINT)

Last Name

First Name

Middle Name

Maiden Name or Alias (if applicable)

Place of Birth

Date of Birth

Social Security Number
(Requested, not required)

ID Theft Index PIN (If applicable)

Mother's Maiden Name

Current And Former Addresses:

Gender: Female Male **Height:** ___ ft. ___ in. **Weight:** _____ **Eye Color:** _____

State Driver License #: _____ **State of Issue:** _____

***** The Above Information was verified by reviewing the following form of Government Issued Photographic Identification:** _____.

Requested by: _____
Signature of CORI Authorized Employee

*The CHSB Identify Theft Index PIN Number is to be completed by those applicants that have been issued an Identity Theft Index PIN Number by the CHSB. Certified agencies are required to provide all applicants the opportunity to include this information to ensure the accuracy of the CORI request process.

All CORI request forms that include this field are required to be submitted to the CHSB via mail or by fax to 617-660-4614.

Program Manager's Signature

Program Manager's Phone