

APPLICATION FOR EMPLOYMENT

Applicants for employment are considered without regard to race, creed, color, religion, sex, sexual orientation, marital status, results of genetic testing, national origin, age, disability, status as a veteran, Vietnam Era Veteran, or being a member of the Reserves or National Guard. Also, 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.

Before you begin the application, please be aware that OPNS requires you to present the following documentation in order to begin working:

- Two forms of identification from the list of approved documents on the Department of Homeland Security's Form I-9.
- 5 Panel Drug Screen
- Any and all state licensing and certifications (RN, LPN, CNA, CHHA, MA, etc.)
- Proof of vehicle insurance (declaration page preferred).
- A note signed by your physician and dated within the past year stating that you are "asymptomatic of communicable disease and able to work without restriction."
- A negative TB test dated within the last year, or a chest x-ray dated within the last five years.

Applicant Name (Last/First/Middle):

Position Applied For: Date of Application:

Home #: Cell #: Referral:

Address: City: Zip:

Email Address:

Are you eligible to work in the United States? Yes No

Are you under 18? Yes No

If employed and you are under 18, can you furnish a work permit? Yes No

Have you ever filed an application here before? Yes No If yes, give date:

Have you ever been employed here before? Yes No If yes, give dates:

Are you employed now? Yes No May we contact your present employer? Yes No

On what date would you be available to begin work?

Are you on a lay-off or subject to recall? Yes No

Indicate Levels of Education and if completed below.

Name and Location of School

Degree/Diploma

Major or Area of Studies

Specify specific areas of health care in which you are trained/experienced. In the blank space below, summarize any specialized training, apprenticeship, activities, honors, skills, and qualifications not evident from above educational experience.

Hoyer Lift
 Psych

Homecare
 IV Cert

Hospice
 Phlebotomy

LTC
 Pediatrics

Alzheimer's

Indicate what languages (including English) you speak, read, and/or write, and at what level of proficiency:

Language:

Fluently Good Fair

Language:

Fluently Good Fair

Language:

Fluently Good Fair

Employment History

Start with your present or last job. Include military service assignments and any verified work performed on a volunteer basis. You may exclude organization names which indicate race, creed, color, religion, sex, sexual orientation, marital status, results of genetic testing, national origin, age, disability, status as a veteran, Vietnam Era Veteran, or being a member of the Reserves or National Guard.

Employer: <input style="width: 90%;" type="text"/>	Phone: <input style="width: 90%;" type="text"/>	Fax: <input style="width: 90%;" type="text"/>
Job Title: <input style="width: 90%;" type="text"/>	Supervisor: <input style="width: 90%;" type="text"/>	Wage: <input style="width: 90%;" type="text"/>
Start Date: <input style="width: 90%;" type="text"/>	End Date: <input style="width: 90%;" type="text"/>	Reason for Leaving: <input style="width: 90%;" type="text"/>
Position Description: <input style="width: 95%;" type="text"/>		
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If you need additional space, paper will be furnished upon request.

O'Connell Professional Nurse Service, Inc.

PROFESSIONAL REFERENCES

Please list 3 professional references. These reference must be from a past manager or supervisor.

REFERENCE 1

NAME: _____

RELATIONSHIP: _____

COMPANY: _____

PHONE NUMBER: _____

REFERENCE 2

NAME: _____

RELATIONSHIP: _____

COMPANY: _____

PHONE NUMBER: _____

REFERENCE 3

NAME: _____

RELATIONSHIP: _____

COMPANY: _____

PHONE NUMBER: _____

***PLEASE SIGN BELOW TO AUTHORIZE THESE REFERENCES TO BE CONTACTED BY
O'CONNELL PROFESSIONAL NURSE SERVICE, INC.***

Name

Signature

Date

**EMPLOYMENT APPLICATION DISCLAIMER
AND ACKNOWLEDGEMENT**

I certify that the information contained in this application is correct to the best of my knowledge. I understand that to falsify information is grounds for refusing to hire me, or for discharge should I be hired.

I authorize any person, organization or company listed on this application to furnish you any and all information concerning my previous employment, education and qualifications for employment. I also authorize you to request and receive such information.

In consideration for my employment, I agree to abide by the rules and regulations of the company, which rules may be changed, withdrawn, added or interpreted at any time, at the company's sole option and without prior notice to me.

I also acknowledge that my employment may be terminated, or any offer or acceptance of employment withdrawn, at any time, with or without cause, and with or without prior notice at the option of the company or myself.

Signature: _____ **Date:** _____

O'Connell

Care at Home | Healthcare Staffing

OCPRN

CH444

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O'Connell Professional Nurse Service, Inc. is requesting all the available criminal offender record information on the following individual from the Criminal History Systems Board pursuant to Chapter 6 §172C that mandates agencies which employ or accept as a volunteer or refer for employment any individual who will provide care, treatment, education, training, transportation, delivery of meals, instruction, counseling, supervision, recreation or other services in a home or in a community based setting for any elderly person or disabled person or who will have any direct or indirect contact with such elderly or disabled persons or access to such person's files shall obtain all available CORI from the Criminal History Systems Board prior to employing such individual, accepting such individual as a volunteer or referring such individual for employment.

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 but not required)

*ID Theft Index PIN
(if applicable)

MOTHER'S MAIDEN NAME

CURRENT AND FORMER ADDRESSES:

SEX: _____ HEIGHT: ft. _____ in. _____ WEIGHT: _____ EYE COLOR: _____

STATE DRIVER'S LICENSE NUMBER: _____
(include state of issue)

***THE INFORMATION WAS VERIFIED WITH 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