APPLICATION FOR EMPLOYMENT

Fairhaven is an equal opportunity employer. All qualified applicants will be considered without regard to age, race, color, sex, religion, national origin, marital status, ancestry, citizenship, veteran status. Sexual orientation or preference, transgender status, physical or ,mental disability, genelie, predisposition or carrier status, or any other category under applicable federal or state law

This application must be completed in its entirely for consideration for employment. Please print legibly.

Name (Last	First	Middle
Present Address (Street and Number	City, State, Zip	Email address
Home Phone	Work Phone	Cell Phone
Position Applied For		Salary Range Desired:
		Are you under 18 years of age? YES NO

General Information

List Names of close relatives employed by Fairhaven

Have you ever been employed by Fairhaven or any affiliate?

____Yes ____No If yes, when and where:____________________

How were you referred to Fairhaven?

Are you eligible to work in the United States? ______Yes ______No

All persons who are offered a position with Fairhaven will be required to present documentation which establishes their identity and eligibility for work in the United States

EDUCATION

Years Completed	School Name Location	Graduate Yes/No	Degree/ Certificate	Major	Honors/Awards
	Technical School/Colleges				
	College University				
	Graduate Study				

Other Studies or courses:

Special Training/Skils:

Employer Name/Address	Supervisor Name & Title	Telephone Number

Employment Dates (Mo/Yr)	Starting Pay	Ending Pay	Reason for Leaving

Job Title	Brief Description of Job Dutie
May we contact this employee? _____Yes_____No	

Employer Name/Address	Supervisor Name & Title	Telephone Number

Employment Dates (Mo/Yr)	Starting Pay	Ending Pay	Reason for Leaving

Job Title	Brief Description of Job Dutie
May we contact this employee? _____Yes_____NO	

Have you ever been discharged by a previous employer or resigned after being told your performance was unsatisfactory?

If Yes, Please Explain:____

SKILLS: Please indicate languages you speak, read, and/or write and indicate level of fluency (fluent, good, fair)

Language	Speak	Read	Write
1.			
2			
3.			

List computers, operating systems, and/or software with which you are familiar

Computers	Operating Systems	Software

REFERENCES: Please list three references whom we may contact concerning your qualifications:

Name:	Company:	Title	Telephone NO.
Name	Company	Title	Telephone NO.
Name	Company	Title	Telephone NO.

PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS

Are you currently registered? ________Registered ________Licensed ________Certified _______Eligible

Type of License/Certificate	License #	Control #	Expiration Date	State

Do you have any prior or pending actions against any of the clinical licenses you have had?

Do you have any pending actions against your professional license, even if it does not impact the status of your license?

Is your current professional license restricted in any fashion?
If so, how is your license restricted

Do you hold a license, degree, certification or other credentials in a healthcare profession from country outside of the U.S?
If yes, whaat document, when was it awarded and from what country?
This information is used for workforce development purposes only. This information is voluntary

EMPLOYMENT HISTORY (Please start with most recent employer)

- Applicants may include in this section any military experiences as well as verified work performed on a voluntary basis. Do not merely state "Refer to resume"

Current or last Employer	Supervisor Name & Title	Telephone Number
Address	Employment Dates (mo/yr) From: To:	Supervisor Email:

Position/Title	Starting Pay	Ending Pay	Reason for Leaving

_____Full Time _____Part Time _____Per Diem _____Temporary	Brief Description of Job Duties: May we contact this employer? _____________Yes___________NO

Employer Name/Address	Supervisor Name & Title	Telephone Number

Employment Dates (Mo/Yr)	Starting Pay	Ending Pay	Reason for Leaving

May we contact this employee? _____Yes_____NO	

Persons employed at Fairhaven have access to confidential information regarding various phases of Company business. Therefore, the company follows the usual practice of requiring new employees, at the time of employment to sign an Employee Confidentiality and Proprietary Information Agreement. Information concerning competitors, operations, o other proprietary information will not be solicited from you for employment, or from Fairhaven employees. Fairhaven will honor any employment restrictions you have with former employees.

DISCLOSURE

I certify that the above information is true, complete, and correct to the best of my knowledge. I represent that I have withheld nothing which, if disclosed, would affect this application unfavorably. I understand that any false statement, misrepresentation or omission made by me on my application, resume, or any other materials I hbe submitted, or during my interviews, can result in denial of employment or , if I am already employed when such false statement, misrepresentation or omission is discovered, immediate termination of my employment. I understand that if employed, my continued employment will be subject to periodic performance evaluations.

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.

I understand that an offer of employment is conditioned upon satisfactory results of a medical examination by medical personnel selected by Fairhaven, to which I hereby consent. I also agree that if I am hired, I will undergo medical examinations at such other times as may be required by Fairhaven during my employment.

I authorize Fairhaven to inquire into my educational, professional and past employment history references as needed to research my qualifications, for this position, including performing a CORI criminal record check. I hereby give my consent to any former employer, educational institution, or Individual harmless from any claims made by me on this institution, or individual and the institution or individual shall not be held liable in any respect if a job offer is not extended or is withdrawn by the Company or if my employment is terminated due to information provided in response to this application as part of the employment process.

I understand that the Immigration Reform and Control Act of 1986 requires that, if hired, I must furnish appropriate documentation to Fairhaven establishing my identity and employment eligibility. If offered by a position by the Company, I agree to provide the Company documents which verify my identity and right to work in the United States within 3 business days of commencing employment as a condition of my employment. The company reserves the right to terminate the employment on any employee failing to produce satisfactory documentation within three (3) days.

I hereby give my consent to Fairhaven to perform the appropriate tests to identify the presence of drugs and alcohol.

I understand that during my employment with Fairhaven, I will be tested under the following circumstances:

Pre-employment- All new employees will be hired on condition of passing a drug and alcohol test. All applicants must sign a consent from before being considered for employment. Those under 18 years of age must have a consent form signed by a parent or legal guardian.

Post Accident-- Fairhaven will make every effort to ensure that all persons involved in any work related accident that results in medical treatment beyond first aid, or that results in property damage of $500 or more, will be tested for use of illicit substances and alcohol.

Reasonable Cause- Fairhaven will require drug and/or alcohol test of any person suspected of using or being under the influence of an illicit drug or alcohol. Reasonable cause testing will be initiated whenever it is believed, through observation of specific physical and/or behavioral systems, that an employee has used an illegal substance and/or abused a legal drug or alcohol. I Further more give my permission for the test results to be released to Fairhaven. I understand that refusal to take any test, attempts to dilute or adulterate specimens, or conduct that in any way obstructs the collection process, will result in the termination of my employment and/or denial of my application with Fairhaven.

I understand that employment at Fairhaven is terminable "at will" which means that the employment relationship can be terminated by either me or the Company at any time and for any reason no prohibited by law. I understand that nothing in this employment Company creates an employment contract between me and the Company. I further understand that no supervisor, manager, or representative of the company other than the Chief Operating Officer has any authority to enter into any agreement for employment for any specified period of time.

I agree that if I am hired will sign all forms and associated HR-related agreements, attend all required orientations and complete all competency based assessments, etc. Failure to comply with these requirements may result in my termination.

In the event of my employment with Fairhaven, I agree to comply with all the Company rules and regulations.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE DISCLOSURES AND ALL THE INFORMATION ON THIS APPLICATION AND HEREBY AGREE AND CONSENT TO SUCH REQUESTS FOR INFORMATION AN OTHER ACTIONS WHICH THE COMPANY MAY TAKE AND DESCRIBED HEREIN.

Signature:______________________________ Date:____________________

Applicant EEO of Affirmative Action
Self-identification Information Request

The purpose of Fairhaven Healthcare is to provide equal opportunity to all qualified applicants for employment without regard to race, color, religion, national origin, gender, age, veteran status, disability, genetic information, or other protected status. As a government contractor, FHV must comply with affirmative action guidelines and regulations as enforced by the U.S. department of Labor, Office of Federal Contract Compliance Programs (OFCCP). The sole purpose of this form is to comply with such requirements.

In order to be considered for employment all applicants must submit their form along with their applications. While the information supplied on the form is voluntary, the requirement to submit the form is not. The information collected on this form will be kept separate from application records and will not be used in the selection and/or hiring process.

Required General Information:

Date: ______________________ Printed Name: ______________________

SSN: ______________________ Position Sought: ______________________

I voluntarily ☐ agree ☐ do not agree to provide the following information. (If you do not agree, please submit this form without going further.)

Ethnic Group:
Are You Hispanic/Latino? (Choose one)☐
☐ Yes ☐ No

Gender Classification:
☐ Male ☐ Female

Race:
If you indicated that you are not Hispanic/Latino, choose one of the following options.
☐ White (Not Hispanic/Latino)
☐ Black/African American (Not Hispanic/Latino)
☐ Asian (Not Hispanic/Latino)
☐ American Indian or Alaskan Native (Not Hispanic/Latino)
☐ Native Hawaiian or Other Pacific Islander(Not Hispanic/Latino)
☐ Two or More Races (Not Hispanic/Latino)

Veteran Status

☐ Disabled Veteran	A veteran of the U.S. military, ground, naval, or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs or a person who was discharged or released from active duty because of a service connected disability.
☐ Other Protected Veteran	A Veteran who served on active duty in the US military, ground, naval or air service during a war or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.
☐ Armed Forces Service Medal	A veteran who, while serving on active duty in the US military, ground, naval, or air service, participated in a United States military operation for which an Armed Forces Services Medal was awarded pursuant to Executive Order 12985
☐ Recently separated Veteran	A veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military ground, naval or air service. Separation date: ______________
☐ Non-Specified Veteran	Served in the armed forces or reserves, with a status different than defined in the choices above

☐ I am not a Veteran

SUBJECT INFORMATION: (An asterisk (*) is a required field)

____

*Last Name | *First Name | Middle Name | Suffix

____

Maiden Name (or other Names 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 Full Maiden Name | Father's Full Name

Current and Former Addresses:

____

Street Number & Name | City/Town | State | Zip

____

Street Number & Name | City/Town | State | Zip

____

The above information was verified by reviewing the following form (s) of government-issued identification:

VERIFIED BY (PRINT)____

VERIFIED BY (SIGNATURE):____

CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM

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

Fairhaven Healthcare Center 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 Fairhaven Healthcare Center 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 Fairhaven Healthcare Center written notice of my intent to withdraw consent to a CORI check.

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

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

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

▶**START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐-☐☐-☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): ____________________

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): ____________
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: ____________________

OR

2. Form I-94 Admission Number: ____________________

OR

3. Foreign Passport Number: ____________________

Country of Issuance: ____________________

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

Employer Completes Next Page

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: ____________ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

<u>Section 1557 Grievance Procedure</u>

It is the policy of Athena Health Care Systems not to discriminate on the basis of race, color, national origin, sex, age or disability. Athena Health Care Systems has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 C.F.R. pt. 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Director of Personnel Management, 135 South Road, Farmington, CT 06032, 1-800-228-4362, fax: 860-751-3905, email: personneldirector@athenahealthcare.com, who has been designated to coordinate the efforts of Athena Health Care Systems to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Athena Health Care Systems to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within 30 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of Athena Health Care Systems relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

Notice of Nondiscrimination

Athena Health Care Systems complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Athena Health Care Systems does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Athena Health Care Systems:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Director of Personnel Management.

If you believe that Athena Health Care Systems has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Director of Personnel Management, 135 South Road, Farmington, CT 06032, 1-800-228-4362, fax: 860-751-3905, email: personneldirector@athenahealthcare.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance the Director of Personnel Management is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Shqip (Albanian):
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-228-4362.

हिंदी (Hindi):
ध्यान द□: य□द आप □हदी बोलते ह □तो आपके ि◌लए मुफ्त म□ भाषा सहायता सेवाएं उपलब्ध ह।□ 1-800-228-4362 पर कॉल कर□।

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-228-4362.

λληνικά (Greek):
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-228-4362.

FOR MANAGEMENT USE ONLY

Interview Sheet

Employee Name: ______________________________

Years of Experience: ____________________________

Interviewed By: ______________________

Notes: ____
____
____
____
____
____
____

Interviewed By: ______________________

Notes: ____
____
____
____
____
____
____

Scheduler ONLY

Status (check one): Full Time: ☐ Part Time: ☐ Per Diem: ☐

Of Hours per week (check one): 37.5: ☐ 32: ☐ 24: ☐ 16: ☐

Shift (check one): 7-3: ☐ 3-11: ☐ 11-7: ☐

Wage: _________________

Unit (check one): Highlands: ☐ Belvidere: ☐ Centralville: ☐ Pawtucketville: ☐

Referral Source (how did they know we were hiring?): _________________________

Scheduler ONLY

FOR MANAGEMENT USE ONLY

TELEPHONE REFERENCE REQUESTS

Applicant's Name ______________________

MOST RECENT PREVIOUS EMPLOYER

Name & Title ______________________ Date __________

Employed by ______________________ From __________

To __________

Duties or position ______________________

Reason for leaving ______________________

Would they re-hire? ☐ Yes ☐ No If no, why not? ______________________

____

____

Attendance	☐ Good	☐ Adequate	☐ Poor
Quality of work	☐ Good	☐ Adequate	☐ Poor
Quantity of work	☐ Good	☐ Adequate	☐ Poor
Cooperation	☐ Good	☐ Adequate	☐ Poor
Initiative	☐ Good	☐ Adequate	☐ Poor

Comments ______________________

____

____

SECOND MOST RECENT PREVIOUS EMPLOYER

Name & Title ______________________ Date __________

Employed by ______________________ From __________

To __________

Duties or position ______________________

Reason for leaving ______________________

Would they re-hire? ☐ Yes ☐ No If no, why not? ______________________

____

____

Attendance	☐ Good	☐ Adequate	☐ Poor
Quality of work	☐ Good	☐ Adequate	☐ Poor
Quantity of work	☐ Good	☐ Adequate	☐ Poor
Cooperation	☐ Good	☐ Adequate	☐ Poor
Initiative	☐ Good	☐ Adequate	☐ Poor

Comments ______________________

____

____

OTHER PREVIOUS EMPLOYER

Name & Title ______________________ Date __________

Employed by ______________________ From __________

To __________

Duties or position ______________________

Reason for leaving ______________________

Would they re-hire? ☐ Yes ☐ No If no, why not? ______________________

____

____

Attendance	☐ Good	☐ Adequate	☐ Poor
Quality of work	☐ Good	☐ Adequate	☐ Poor
Quantity of work	☐ Good	☐ Adequate	☐ Poor
Cooperation	☐ Good	☐ Adequate	☐ Poor
Initiative	☐ Good	☐ Adequate	☐ Poor

Comments ______________________

____

____