



## APPLICATION FOR EMPLOYMENT

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| <input type="checkbox"/> Health Concepts, Ltd.<br>359 Broad Street, Providence, RI 02907               | <input type="checkbox"/> Bayberry Commons<br>181 Davis Drive, Pascoag, RI 02859   |
| <input type="checkbox"/> DMR Construction, LLC<br>359 Broad Street, Providence, RI 02907               | <input type="checkbox"/> West Shore Health Center<br>109 West Shore Road, Warwick, RI 02889                                 |
| <input type="checkbox"/> Riverview Healthcare Community<br>546 Main Street, Coventry, RI 02816         | <input type="checkbox"/> S. Kingstown Nursing & Rehab Center<br>2115 S. County Trail, PO Box 307<br>West Kingston, RI 02892 |
| <input type="checkbox"/> Village House Nursing & Rehab Center<br>70 Harrison Avenue, Newport, RI 02840 | <input type="checkbox"/> Pine Grove Health Center<br>999 S. Main Street, Pascoag, RI 02859                                  |
| <input type="checkbox"/> Elmwood Nursing & Rehab<br>225 Elmwood Avenue, Providence, RI 02907           | <input type="checkbox"/> Woodpecker Hill Health Center<br>2052 Plainfield Pike, Greene, RI 02827                            |
| <input type="checkbox"/> Morgan Health Center<br>80 Morgan Avenue, Johnston, RI 20919                  | <input type="checkbox"/> Heritage Hills Nursing & Rehab<br>80 Douglas Pike, Smithfield, RI 02917                            |
| <input type="checkbox"/> Westerly Health Center<br>280 High Street, Westerly, RI 02891                 | <input type="checkbox"/> Eastgate Nursing & Rehab Center<br>198 Waterman Ave., E. Providence, RI 02914                      |

*An Equal Opportunity Employer*

*Our facilities are subject to the provisions of Chapters 29-38  
of the Rhode Island Workers' Compensation Law.*

## Application for Employment

PLEASE READ CAREFULLY -- ANSWER ALL QUESTIONS -- PRINT CLEARLY IN INK

### PERSONAL

Last Name	First Name	Middle Initial	Social Security Number
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Home Address	Street	Apt.	City	State	Zip
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Home Phone	Cell Phone	In case of emergency, Notify: (Name, Address, Telephone)
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Are you either a US citizen or an alien who is authorized to work in the US? YES \_\_\_ NO \_\_\_

You must complete the I-9 Form required by the US Citizenship & Immigration Services no later than three (3) business days after your date of hire.

Have you ever been convicted of a felony as defined by RIGL 27-17-37 that would disqualify you from working in healthcare? Yes \_\_\_ No \_\_\_

As a condition of employment, ALL applicants are required to provide a fingerprint-based national background check from the Office of the Attorney General, 150 S. Main Street, Providence, RI

Have you ever served in the US Armed Forces? Yes \_\_\_ No \_\_\_

Have you previously been employed by a Health Concepts, Ltd facility? (Laurel, Riverview, Village House, Elmwood, Morgan, Westerly, Bayberry, West Shore, S. Kingstown, Pine Grove, Woodpecker Hill, Heritage Hills, Eastgate)?

Yes \_\_\_ No \_\_\_ If yes, Location: \_\_\_\_\_ Dates: \_\_\_\_\_

### JOB INTEREST

How did you learn of this job opening?

Position(s) Desired:	First Choice	Second Choice	Date Available	Salary/Rate Desired
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Work Hours/ Shift Preferred:	Full Time Yes ___ No ___	Part Time Yes ___ No ___	Per Diem Yes ___ No ___	Days Yes ___ No ___	Evenings Yes ___ No ___	Nights Yes ___ No ___	Weekends Yes ___ No ___
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### EDUCATIONAL RECORD

Circle Highest Grade Completed:	Grade School/High School 1 2 3 4 5 6 7 8 9 10 11 12	College/Graduate School 1 2 3 4 5 6
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Schools Attended:	Name	City/Town	Major Field
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Last High School \_\_\_\_\_

Last College/University/Nursing Schools \_\_\_\_\_

Graduate School \_\_\_\_\_

Technical or Vocational School \_\_\_\_\_

List courses in which you are currently enrolled: \_\_\_\_\_

### PROFESSIONAL LICENSURE/CERTIFICATION(S)

Type	State Issued	Date Issued	Expires On	Number
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Have you ever held, or do you currently hold, a license in another state? Yes \_\_\_ No \_\_\_ If yes, please list \_\_\_\_\_

Have you ever held, or do you currently hold, a license in another name? Yes \_\_\_ No \_\_\_ If yes, please list \_\_\_\_\_

Are there any charges or investigations pending, in any state, against you? Have your staff privileges at any hospital, nursing home, or other health care facility, or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state? Have you ever had any disciplinary action(s) taken or is any pending against your license to practice nursing, or any other licenses, registrations or certifications that you hold, or are any complaints pending in any state?

If the answer is yes to any of the above questions, please explain below: (use additional paper if necessary)

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## WORK EXPERIENCE

May we contact your present employer? Yes \_\_\_\_\_ No \_\_\_\_\_

Is any additional information relative to change of name, use of an assumed name or nickname necessary to enable a check on your work and educational record? \_\_\_\_\_

List your last/present employer first (including volunteer experience) and account for any lapse of time between employment.

Employer	Employed from:	To:
Street Address	City	State Phone
Position Title	Salary:	Starting Final
Supervisor's Name & Title	Person(s) We May Contact	
Briefly describe your duties	Reason for Leaving	

Employer	Employed from:	To:
Street Address	City	State Phone
Position Title	Salary:	Starting Final
Supervisor's Name & Title	Person(s) We May Contact	
Briefly describe your duties	Reason for Leaving	

Employer	Employed from:	To:
Street Address	City	State Phone
Position Title	Salary:	Starting Final
Supervisor's Name & Title	Person(s) We May Contact	
Briefly describe your duties	Reason for Leaving	

## REFERENCES

Please list the names of three (3) people that we may contact (other than current & past employers & family members):

Name	Address	How Known/Years Known	Phone #
1)			
2)			
3)			

**Health Concepts, Ltd. and its facilities are committed to the provision of equal employment opportunities to its applicants regardless of race, age, sex, religion, national origin, disability, color, religion, creed, liability for service in the armed forces of the United States, citizenship or any other characteristic protected by applicable State or Federal laws.**

**Please Read the Following Carefully Before Signing This Application Form:**

I understand that if hired my employment will be on a 90-day introductory basis, and that as long as I am employed by a Health Concepts, Ltd. facility, my employment may be terminated, with or without cause or notice, at any time, at my option or that of the facility. I understand that no management representative has any authority to enter into any agreement for continuing employment for any specific period of time that is contrary to the foregoing.

I give Health Concepts, Ltd. and/or its facilities permission to contact any or all of my previous employers and references and authorize them to provide all information requested of them by the facility. I authorize Health Concepts, Ltd. and/or its facilities to obtain, use and rely upon that information in relation to my application and release Health Concepts, Ltd. and/or its facilities and all providers of such information from all liability in connection with the use of such information. I have provided truthful and complete responses to all inquiries in the application and understand that the discovery of any falsification or omission may disqualify me for further consideration for employment or result in my discharge from employment. If employed by Health Concepts, Ltd. and/or its facilities, I will abide by its rules and regulations which I understand are subject to change by Health Concepts, Ltd. and/or its facilities.

If hired, I understand that commencement of employment is conditioned upon successful completion of a physical exam, employee orientation and background check.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**For Office Use Only**

Start Date: \_\_\_\_\_

Department: \_\_\_\_\_

Position: \_\_\_\_\_

Rate of pay: \_\_\_\_\_

Status:(F/T, P/T, Perdiem) \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_