Health Concepts, Ltd.
Nursing, Rehabilitation, Memory Care

APPLICATION FOR EMPLOYMENT

☐ **Village House Nursing & Rehab Center**
70 Harrison Avenue, Newport, RI 02840

☐ **Elmwood Nursing & Rehab**
225 Elmwood Avenue, Providence, RI 02907

☐ **Bayberry Commons**
181 Davis Drive, Pascoag, RI 02859

☐ **West Shore Health Center**
109 West Shore Road, Warwick, RI 02889

☐ **S. Kingstown Nursing & Rehab Center**
2115 S. County Trail, PO Box 307
West Kingston, RI 02892

☐ **Eastgate Nursing & Rehabilitation Center**
198 Waterman Avenue
East 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

Home Address | Street | Apt. | City | State | Zip

Home Phone | Cell Phone | In case of emergency, Notify: (Name, Address, Telephone)

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, 4 Howard Ave., Cranston, RI.

Have you ever served in the US Armed Forces? Yes____ No____

Have you previously been employed by a Health Concepts, Ltd facility? (Riverview, Village House, Elmwood, Morgan, Westerly, Bayberry, West Shore, S. Kingstown, 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

Work Hours/	Full Time	Part Time	Per Diem	Days	Evenings	Nights	Weekends
Shift Preferred:	Yes__ No__	Yes__ No__	Yes__ No__	Yes__ No__	Yes__ No__	Yes__ No__	Yes__ No__

EDUCATIONAL RECORD

	Grade School/High School	College/Graduate School
Circle Highest Grade Completed:	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6

Schools Attended: | Name | City/Town | Major Field

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

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)

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 faciliites.

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: _____

NATIONAL BACKGROUND CHECK PROGRAM

APPLICANT REGISTRATION FORM

You have been offered the position of _____. Per state law, all long-term care facilities are required to conduct a national criminal background check prior to you starting work. As such, we will check the following databases:

- National Sex Offender Registry
- Rhode Island Sex Offender Registry
- Excluded Parties List System
- Office of the Inspector General Exclusions List
- Rhode Island Nurses Aide Registry & License
- Rhode Island Disciplinary Actions Database
- Rhode Island Court Connect Defendant Search Database

The following information is required and will be used for the sole purpose of registration for the criminal background check. The job offer will not be based on any of the information provided on this form. However, employment is contingent upon the results of the background check from all databases.

PLEASE PRINT CLEARLY

Last Name: _____

First Name:_____ Middle Name: _____

Maiden Name or any other former names: _____

Date of Birth: ___/___/___ Place of Birth (State/Country):_____

SSN: _____-_____-_____ Sex: M F

Race (circle one): American Indian/Alaskan Native Asian/Pacific Islander Black

White including Latino Unknown

Eye Color:_____ Hair Color: _____ Height: _____ Weight: _____

Country of Citizenship: _____

Driver's License Number: _____ Driver's License State: _____

Address: _____

City, State, Zip: _____

Email: _____

By signing this form, you agree to use this information as a requirement for the National Criminal Background Check. You will then be provided with a registration letter to bring with you to the Office of the Attorney General at 4 Howard Avenue, Cranston, RI to obtain a fingerprint-based national background check. The cost will be $45. Results will be sent to the email provided above.

Signature: _____ Date: _____