



**HATTIE IDE CHAFFEE HOME**

**EMPLOYMENT APPLICATION**

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

**PERSONAL INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Email: \_\_\_\_\_

Position Applying for: \_\_\_\_\_ Are you over the age of 18?  YES  NO

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**AVAILABILITY**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning <input type="checkbox"/>	Morning <input type="checkbox"/>	Morning <input type="checkbox"/>	Morning <input type="checkbox"/>	Morning <input type="checkbox"/>	Morning <input type="checkbox"/>	Morning <input type="checkbox"/>
Afternoon <input type="checkbox"/>	Afternoon <input type="checkbox"/>	Afternoon <input type="checkbox"/>	Afternoon <input type="checkbox"/>	Afternoon <input type="checkbox"/>	Afternoon <input type="checkbox"/>	Afternoon <input type="checkbox"/>
Evening <input type="checkbox"/>	Evening <input type="checkbox"/>	Evening <input type="checkbox"/>	Evening <input type="checkbox"/>	Evening <input type="checkbox"/>	Evening <input type="checkbox"/>	Evening <input type="checkbox"/>
Night <input type="checkbox"/>	Night <input type="checkbox"/>	Night <input type="checkbox"/>	Night <input type="checkbox"/>	Night <input type="checkbox"/>	Night <input type="checkbox"/>	Night <input type="checkbox"/>

Are there any specific hours that you are not available for work? If so, please list below:

\_\_\_\_\_

**EDUCATION**

Type of School	Name of School	Address	Number of Years Completed?	Major/Degree
High School				
College				
Trade School				
Graduate School				

HAVE YOU EVER BEEN CONVICTED OF A CRIME?  YES  NO

If yes, explain the number of convictions, the nature of the offense(s) leading to the conviction(s), how recently was/were the offense(s) committed, sentence(s) imposed, and type(s) of rehabilitation.

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Please list any two references personal/professional references.

Name: \_\_\_\_\_

Name: \_\_\_\_\_

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

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

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

**EMPLOYMENT HISTORY**

Please list your work experience starting with our most recent employer.

Employer Name Address and Phone Number	Name of Last Supervisor	Employment dates	Pay
		From:  To:	Start:  End:
		Last Job title:	
Job Duties and Responsibilities		Reason for Leaving:	

Employer Name Address and Phone Number	Name of Last Supervisor	Employment dates	Pay
		From:	Start:
		To:	End:
		<b>Last Job title:</b>	
<b>Job Duties and Responsibilities</b>		<b>Reason for Leaving:</b>	

Employer Name Address and Phone Number	Name of Last Supervisor	Employment dates	Pay
		From:	Start:
		To:	End:
		<b>Last Job title:</b>	
<b>Job Duties and Responsibilities</b>		<b>Reason for Leaving:</b>	

Employer Name Address and Phone Number	Name of Last Supervisor	Employment dates	Pay
		From:	Start:
		To:	End:
		<b>Last Job title:</b>	
<b>Job Duties and Responsibilities</b>		<b>Reason for Leaving:</b>	

Please list any additional skills, qualifications, certifications, or training that you feel is relevant to this position (e.g., speak a foreign language, CPR, or other training or special education).

**For Skilled Nurses/Nursing Assistants Only**

**Specialty: Check all that apply**

<input type="checkbox"/> Medical/Surgical	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Autism
<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Hospice	<input type="checkbox"/> Other
<input type="checkbox"/> Case Management	<input type="checkbox"/> Home Health	
<input type="checkbox"/> Director of Nursing	<input type="checkbox"/> Alzheimer's or Dementia	

**Experience**

<input type="checkbox"/> less than a year	<input type="checkbox"/> 1-3 years	<input type="checkbox"/> 3-5 years	<input type="checkbox"/> More than 5 years
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**Do you have a current license?**  YES  NO

If so, in which states?

Has your nursing license ever been suspended or revoked?  YES  NO

Have you ever been disciplined for being unprofessional or unethical nursing to include abuse or neglect?

YES  NO

If so, explain

**Skills Inventory**

	Years of Experience	Training		Years of Experience	Training		Years of Experience	Training
Hospital			Transfer ROM			Geriatric Care		
Nursing Home			Bathing			Pediatric Care		
Private Home			TPR			Psychiatric Care		
Meal Prep			Blood Pressure			AIDS Care		
Special Diets			Dressing Change			Maternal		
CVA			Warm/Cold Compress			Intellectual Disability Care		
IV Therapy			Respiratory Care			Alzheimer's Care		
Foley Care			Ostomy Care			Oncology/Hospice Care		
Tracheostomy			Ventilator					



HATTIE IDE CHAFFEE HOME

200 Wampanoag Trail  
East Providence, RI 02915  
Tel 401-434-1520 Fax 401-438-8494

## Reference Check

To whom it may concern:

I have applied to Hattie Ide Chaffee Home for employment and hereby authorize this agency to request such information as necessary to verify information given by me on the application form. I also authorize you to release this information.

Print applicant Name: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Requested by: **Sylvianne DaGraca**

Title: **Human Resources**

## Employment Reference Check

Dates of employment: \_\_\_\_\_ to \_\_\_\_\_ Position Held: \_\_\_\_\_

Reason for separation: \_\_\_\_\_

\_\_\_\_\_

Would you re-employ? \_\_\_\_\_ Yes \_\_\_\_\_ No

Name of Company: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_





