Community Healthlink
A Member of UMass Memorial Health Care

EMPLOYMENT APPLICATION

Date _____

POSITION(S) applied for - list in order of preference:

1. 2. 3.

PERSONAL

Last Name	First Name	Middle Initial	Maiden Name (If applicable)	
Address (Number & Street, Apartment or Box No.)		City	State	Zip
Home Phone	Work Phone	Cell/Mobile Phone	Best Way to Contact	
E-mail Address:				

Desired Type of Employment	Desired Shift	Are you eligible to work in the U.S.?	Are you age 18 years or older?
☐ Full-Time ☐ Part-Time ☐ Temporary	☐ 1st (7am – 3pm) ☐ 2nd (3pm – 11pm) ☐ 3rd (11pm – 7am) ☐ Varied (Any)	☐ Yes ☐ No Proof of citizenship or immigration status will be required upon employment.	☐ Yes ☐ No

Have you ever been previously employed by Community Healthlink?	If yes, list dates employed:		Desired Salary
☐ Yes ☐ No	From:	To:	
	Program(s):		

EDUCATION

School/Institution (City, State)	Did you Graduate?	Major/Area of Study	GPA	Degree / Date of Graduation
1. **High School** Name: _____ City, State: _____	☐ Yes No ☐ Currently Enrolled			Degree: Date of Graduation:
2**. College/University** Name: _____ City, State: _____	☐ Yes ☐ No ☐ Currently Enrolled			Degree: Date of Graduation:
3. **Graduate School** Name: _____ City, State: _____	☐ Yes ☐ No ☐ Currently Enrolled			Degree: Date of Graduation:
4. **Other** Name: _____ City, State: _____	☐ Yes ☐ No ☐ Currently Enrolled			Degree: Date of Graduation:

WORK EXPERIENCE

Are you currently employed? ☐ Yes ☐ No

If yes, may we contact your present employer? ☐ Yes ☐ No

Begin with present or most recent employer and list prior employers. You may include any verifiable work performed on a voluntary basis.

1. Name of Employer		Address	City	State	Zip Code
Dates Employed		Salary		☐ Full-Time ☐ Intern/Volunteer ☐ Part-Time ☐ Temporary	Your Job Title:
From:	To:	Start:	End:		
Phone:		Supervisor's Name:		Supervisor's Title:	
Describe Major Duties:				Reason For Leaving:	

2. Name of Employer		Address	City	State	Zip Code
Dates Employed		Salary		☐ Full-Time ☐ Intern/Volunteer ☐ Part-Time ☐ Temporary	Your Job Title:
From:	To:	Start:	End:		
Phone:		Supervisor's Name:		Supervisor's Title:	
Describe Major Duties:				Reason For Leaving:	

3. Name of Employer		Address	City	State	Zip Code
Dates Employed		Salary		☐ Full-Time ☐ Intern/Volunteer ☐ Part-Time ☐ Temporary	Your Job Title:
From:	To:	Start:	End:		
Phone:		Supervisor's Name:		Supervisor's Title:	
Describe Major Duties:				Reason For Leaving:	

4. Name of Employer		Address	City	State	Zip Code
Dates Employed		Salary		☐ Full-Time ☐ Intern/Volunteer ☐ Part-Time ☐ Temporary	Your Job Title:
From:	To:	Start:	End:		
Phone:		Supervisor's Name:		Supervisor's Title:	
Describe Major Duties:				Reason For Leaving:	

MILITARY SERVICE

Branch	Start Date	End Date	Highest Rank Attained	Duties

LICENSES/CERTIFICATIONS HELD (Please check all that apply)

☐ PhD ☐ PsyD ☐ Ed D ☐ Other:	☐ LICSW ☐ LCSW ☐ LMHC ☐ LMFT ☐ LADC – I ☐ LADC – II ☐ Other:	☐ NP ☐ RNCS ☐ RN ☐ LPN ☐ CNA ☐ EMT ☐ Other:	☐ PT OT ☐ SLP ☐ ABA ☐ Other: ☐	☐ CAGS ☐ MAPS ☐ CPR ☐ Other:

FOREIGN LANGUAGE PROFICIENCY

	LEVEL OF PROFICIENCY							
	ORAL				WRITTEN			
	Fluent	Good	Fair	N/A	Fluent	Good	Fair	N/A
SPANISH	☐	☐	☐	☐	☐	☐	☐	☐
PORTUGESE	☐	☐	☐	☐	☐	☐	☐	☐
VIETNAMESE	☐	☐	☐	☐	☐	☐	☐	☐
MANDARIN	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (please indicate)	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐

OTHER SKILLS/QUALIFICATIONS

Please list other job related skills and qualifications:

SUMMARY

In a brief statement, **in your own words**, please describe why you are an ideal candidate for the position(s) for which you are applying for at Community Healthink, Inc.

Were you referred to CHL by a CHL Employee? Yes ____ No _____

If yes, provide name of CHL Employee: _____

REFERENCES Community Healthlink requires (3) supervisory work references. **Personal references are not accepted**. If you are a graduating student with limited work history, please include professional references.

Name	Company you worked at with this reference provider	Relationship	Phone	E-mail

**** WE ARE AN EQUAL OPPORTUNITY AFFIRMATIVE ACTION EMPLOYER AND DO NOT DISCRIMINATE AGAINST ANY PERSON ON THE BASIS OFRACE RELIGION, COLOR, NATIONAL ORIGIN, GENDER, AGE, , VETERAN STATUS, SEXUAL ORIENTATION, DISABILITY OR ANY OTHER CATEGORY PROTECTED BY LAW.**

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 certify that all the information that I have provided on this application is true and complete to the best of my knowledge. Any misrepresentation or omission of any fact in my application, resume, or other materials, or during interviews, can be justification for refusal of employment, or, if employed, termination from employment.

I authorize and request that all of my present and former employers and those individuals I have listed as personal references furnish information about my employment record, including a statement of the reason for the termination of my employment, work performance, abilities, and other qualities pertinent to my qualifications for employment. I hereby release my present and former employers, those individuals I have listed as personal references and Community Healthlink from any and all liability for damages arising from furnishing the requested information. I understand that if I refuse to provide such authorization, my application for employment will not be considered.

I understand that this Application for Employment is not an offer of employment. I understand that nothing contained in this employment application creates a contract between Community Healthlink and myself for employment or any other benefit. No promises regarding employment have been made and I understand that no such promise or guarantee is binding upon Community Healthlink. I understand that if I am hired, I will be an employee "at will," meaning I am not hired for any definite length of time and either I or Community Healthlink can terminate my employment at any time for any or no reason.

My typed name below shall have the same force and effect as my written signature.

_____ _____

Signature of Applicant Date

CORI REQUEST FORM

COMMUNITY HEALTHLINK has been certified by the Criminal History Systems Board for access to all conviction and pending criminal case data.

As an applicant/employee for the positions of _____, _____
I understand that a record check will be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. I further understand and agree that periodic checks maybe conducted during my employment at Community Healthlink, Inc. The information below is correct to the best of my knowledge.

_____ _____
Applicant / Employee Signature (Unless otherwise preempted by law) Date

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 (Last six digits required) ID Theft Index PIN (If applicable)

_____
Mother's Maiden Name

Current And Former Addresses:

_____

_____

Gender: ☐ Female ☐ Male Height: ft. in. Weight: _____ Eye Color: _____

State Driver's License #: _____ State of Issue: _____

*** The Above Information was verified by reviewing 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.

_____ _____
Program Manager's Name (Print) Program Manager's Phone

_____
Program Manager's Signature