Masonicare

Application for Employment

Please complete all questions on this employment application so that you may be given every employment consideration. It is the policy of Masonicare to provide equal employment opportunities to all employees and applicants for employment without regard to sex, race, color, religion, national origin, age, disability, veteran status, marital status or sexual orientation. Masonicare complies with applicable state and local laws governing nondiscrimination in employment in every location in which we have employees.

Please notify the Human Resources office if you require accommodation to successfully complete the application process, i.e. sign interpreter, etc.

Masonicare is an organization including the following affiliates: Masonicare Health Center, Masonicare Home Health & Hospice, Masonicare Partners Home Health & Hospice, Masonicare at Newtown, Masonicare Corporate Services, Masonicare at Ashlar Village, Masonic Management Services, Masonicare at Home, and The Masonic Charity Foundation of Connecticut, hereafter referred to as "employer."

*Date*_____

Position Applying For:	**Full Time** _____ **Part Time** _____ **Per Visit** _____ **Temporary** _____	**Per Diem** _____ **Hours Preferred** ____ **Shift Preferred** _____	**Social Security Number:**
Name (Last)	(First)	(Middle)	Have you ever been known by another name?

Present Address:	**City:**	**State:**	**Zip:**

Home Telephone: (_____) _____

Cell Phone: (_____) _____

E-mail Address: _____

Work Telephone: _____

Are you eligible to work in the United States? Yes ❑ No ❑ **If hired you must complete a Federal Form I-9.**

I can perform the essential functions of the position for which I am applying [ ] with or [ ] without reasonable accommodations.

Education (circle last year completed):

6 7 8 9 10 11 12 13 14 15 16

Are you at least 18? Yes ❑ No ❑

School	Name and City	Graduate	Major	Degree
High School				
College				
Other				

U.S. Military? Yes ❑ No ❑	**Branch:**	**Type of Discharge:**	**Rank:**

Previous employee of Masonicare or affiliates: Yes ❑ No ❑

If yes, when?

Any relatives employed by us? Yes ❑ No ❑

Relationship: Department:

How were you referred to us? Please specify.

Give the names and addresses of 3 persons <u>OTHER THAN REALTIVES</u> (i.e. co-workers/supervisors) who you know and can provide information about your work.

Name	Address	Phone Number	Relationship
		( )	
		( )	
		( )	

May we contact your present and/or past employer?

Yes ❑ No ❑ If no, explain:

Starting with the most recent position, state your last four employers.

1	Company Name:		Telephone: ( ) _____	
	Address:	City:	State:	Zip:
	Employed (state month and year) From_____ To _____	Name of Supervisor:	Starting Wage _____ Ending Wage _____	
	State Job Title and Describe Work:	Reason for Leaving		

2	Company Name:		Telephone: ( ) _____	
	Address:	City:	State:	Zip:
	Employed (state month and year) From_____ To _____	Name of Supervisor:	Starting Wage _____ Ending Wage _____	
	State Job Title and Describe Work:	Reason for Leaving:		

3	Company Name:		Telephone: ( ) _____	
	Address:	City:	State:	Zip:
	Employed (state month and year) From_____ To _____	Name of Supervisor:	Starting Wage _____ Ending Wage _____	
	State Job Title and Describe Work:	Reason for Leaving:		

4	Company Name:		Telephone: ( ) _____	
	Address:	City:	State:	Zip:
	Employed (state month and year) From_____ To _____	Name of Supervisor:	Starting Wage _____ Ending Wage _____	
	State Job Title and Describe Work:	Reason for Leaving:		

All applicants, including administrative, management and supervisory are required to answer the following questions:	
1.	Are you currently, or have you ever been excluded, suspended, debarred, or otherwise deemed ineligible to participate in Federal healthcare programs (i.e. Medicare, Medicaid, etc.)? Yes ❑ No ❑
2.	If you answered "yes" to the above question, on what date were you reinstated in the Federal healthcare program after your period of exclusion, suspension, debarment, or ineligibility?
3.	Have you ever been subject to any disciplinary action regarding cruelty or assault? Yes ❑ No ❑ If "yes" please explain _____
4.	Have you ever been involuntary terminated from a prior position? Yes ❑ No ❑ If "yes" please explain _____

Clinical Section – Please Complete Appropriate Categories.

C.N.A./H.H.A. (circle one)	Registry # _____	Issue Date: _____
R.N./L.P.N. (circle one)	License # _____	Expiration Date: _____
M.D.	License # _____	Expiration Date: _____
P.T.	License # _____	Expiration Date: _____
O.T.	License # _____	Expiration Date: _____
R.T.	License # _____	Expiration Date: _____
Audiology	License # _____	Expiration Date: _____
Speech	License # _____	Expiration Date: _____
Other	License # _____	Expiration Date: _____

Are there any actions, past or pending, against your certification or licensures, such as limitations, suspensions or revocations? Yes ❑ No ❑

If yes, please explain _____

_____

Have you ever been sanctioned or excluded by/from any Federal or State healthcare plan? Yes ❑ No ❑

If yes, please explain _____

_____

Training Skills Acquired – Please Compete Appropriate Categories.

Basic Cardiac Life Support	_____	Date Completed: _____
Advanced Cardiac Life Support	_____	Date Completed: _____
Coronary Care Course	_____	Date Completed: _____
Respiratory Care Course	_____	Date Completed: _____
I.V. Therapy Course	_____	Date Completed: _____
Other Courses	_____	
	_____	

Clerical Section

Keyboard _____ wpm MS Word _____ MS Tables _____

Power Point_____ Excel _____ Other _____

Switchboard _____ Access/DB II, III, Other _____ _____

Maintenance Section – Please Complete Appropriate Categories.

Plumber License # _____ Expiration Date: _____

Boiler Engineer License # _____ Expiration Date: _____

Electrician License # _____ Expiration Date: _____

HVAC License # _____ Expiration Date: _____

Special Skills _____

I, the undersigned certify that the information contained in the employment application is true and complete to the best of my knowledge and belief. I understand and agree that omissions, misrepresentations, or falsifications of any part of this record shall be cause for immediate discharge without severance benefits in the event that I am hired.

I understand that this application and/or any resultant employment does not imply or indicate any intent if establishing any contractual relationship. I further understand that my employment is at will and can be terminated by me or the employer at any time, for any reason. Also, I understand that this application is not an offer of employment, and offers of employment may only be made in writing by the Human Resources designee.

I understand that any resultant employment is contingent on the satisfactory processing of my application and post offer medical examination inclusive of screenings for drug, alcohol, and functional capability.

I understand that I will be considered for employment on the basis of references and the information furnished on this application form and I hereby authorize all schools, former employers, personal references, police and government agencies to furnish full information including work history, any personnel file information, and information regarding any exclusion from Federal healthcare program participation to Masonicare without liability of any kind.

_____ _____

Signature Date

Masonicare Health Center • 22 Masonic Avenue • P.O. Box 70 • Wallingford, CT 06492

Masonicare Home Health & Hospice • 33 North Plains Industrial Road • Wallingford, CT 06492

Masonicare Partners Home Health & Hospice • 111 Founders Plaza, Suite 200 • East Hartford, CT 06108

Masonicare at Ashlar Village • Cheshire Road • P.O. Box 70 • Wallingford, CT 06492

Masonicare at Newtown • Toddy Hill Road • P.O. Box 5505 • Newtown, CT 06470

Masonicare Corporate Services • 22 Masonic Avenue • P.O. Box 70 • Wallingford, CT 06492

Recruitment Center Phone: 203-679-5113 Toll Free: 888-635-6664 Fax: 203-679-3052

www.masonicare.org

The Masonicare HelpLine: 888-679-9997

Masonicare

Addendum to Application for Employment

Applicant Name_____ **Date of Application**_____

Criminal History

All applicants, including those applying for administrative, management and supervisory positions are required to answer the following questions:

1. Have you ever been convicted of a crime, including any related to the provision of healthcare items or services? [ ] Yes [ ] No If yes, please explain. _____

   _____

   _____

   "Conviction" for this application, means a final judgment or verdict of guilty, a plea of guilty, or a plea of nolo contendere, in any state or federal court, regardless of whether an appeal is pending or could be taken.

   "Conviction" does not include a final judgment or verdict that has been expunged by pardon, reversed, set aside or otherwise rendered invalid. Further, you are **not required to disclose** any arrest(s), criminal charge(s) or conviction(s) the record(s) of which have been **erased under law**. Such records can include records of a finding of delinquency or that a child was a member of a family with service needs, adjudication of youthful offender status, criminal charges dismissed or nolled, or charges for which a person is found not guilty or a conviction later resulting in an absolute pardon.

   Further, any person whose criminal records have been erased is deemed under law never to have been arrested with respect to such erased proceedings and may so swear under oath.

   A history of criminal conviction(s) will not necessarily bar consideration of employment. Factors such as the time, seriousness and nature of the offense, as well as rehabilitation, will be taken into account.

   Should you have any questions regarding this application, or your rights concerning erased records, please direct inquires to the Human Resources Department.

2. Are there any criminal charges currently pending against you, including any related to the provision of healthcare items or services? [ ] Yes [ ] No If yes, please explain. _____

   _____

   _____

I understand this insert regarding Criminal History is an addendum to the Masonicare Application for Employment.

Applicant Signature_____ Date_____

Masonicare Corporation
22 Masonic Avenue
Wallingford, CT 06492

NOTIFICATION AND AUTHORIZATION FOR BACKGROUND CHECK

I hereby authorize Strategic Information Resources, Inc. and/or their agents to investigate my background for employment purposes. I acknowledge that under the Fair Credit Reporting Act, as amended by the Fair And Accurate Credit Transactions Act of 2003, I have been informed that this background check will consist of investigative consumer reports which may include information about my character, criminal record, work habits, credit background, academic-credential verification, job experience and reasons for termination. Also, it may include information about my workers' compensation claim history, driving record or abstract, personal characteristics, general reputation and mode of living. I acknowledge that these reports may be obtained at any time after receipt of my authorization, and if I am hired, throughout my employment. American Driving Records will supply Louisiana driving records.

I am aware that in the event an investigative consumer report is prepared, I am entitled request additional disclosures regarding the nature and scope of the investigation being requested as well as a written summary of my rights under the Fair Credit Reporting Act.

I authorize and release from all liability, without reservation, the consumer reporting agency (CRA) and any law enforcement agency, administrator, state/federal agency, institution, information service bureau, employer, employee, insurance company or person gathering or providing information, to complete this investigation.

Prior to an adverse employment decision being made, due totally or partially to information obtained from a consumer report, Masonicare Corporation will provide me with a copy of the report, a summary of my rights under the Fair Credit Reporting Act as amended by the Fair And Accurate Credit Transactions Act of 2003, and the source of the report so that I may contact them, if I wish to do so.

My signature below certifies that this authorization and the accompanying application and other documents were completed by myself and are complete and true to the best of my knowledge. This release will remain valid unless revoked in writing.

Copies and facsimile copies of this document may be accepted in lieu of the original.

Applicant Signature _____ Signature Date _____

Printed Name _____ Drivers License # _____ State _____

Social Security Number _____ Date of Birth _____

Current Address _____ City _____ State _____ ZIP _____

Previous Address _____ City _____ State _____ ZIP _____

Please list any aliases that you have used in past seven years. *(This may include abbreviated names,* ***maiden names*** *, or prior legal names)*

Oklahoma Residents *: Check here if you would like a copy of the background check results mailed to you:* ☐

California Residents *: Check here if you would like a copy of the background check results mailed to you:* ☐