First Atlantic HealthCare

Application for Employment

We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital or veteran status, sexual orientation, or any other legally protected status. Reasonable accommodations to enable all individuals to participate in the application process will be provided upon advance request. Employment is conditioned upon the successful completion of a Criminal Background and License/Certification Check. If Hired, All Employees must be able to provide a valid form of Photo Identification (i.e. Driver's License, Passport, Student ID, SS Card, Proof of citizenship or immigration status, etc.)

Thank you for your interest in our Healthcare Organization. **Please Print**

Position(s) applying for			**Date of Application**
How did you learn about us?			
Last Name	**First Name**		**Middle Name**
Street Address	**City**	**State**	**Zip**
Contact Number – Home	**Contact Number - Cell**		
Other Known Names (if applicable): ____________________ ____________________			

If you are under 16 years of age, can you provide required proof of your eligibility to work?	Yes	No
Have you ever filed an application with us before? If Yes, Date	Yes	No
Have you been employed before with us or any FAH affiliated company? If Yes, Facility Date	Yes	No
Are you currently employed?	Yes	No
May we contact your current employer?	Yes	No
Are you legally eligible for employment in the United States? (If offered employment, you will be required to provide documentation to verify eligibility).	Yes	No
On what date would you be available for work?		
Are you available for: Full Time Part Time Shift Work Temporary (Temp Dates)		
Can you travel if the job requires it?	Yes	No
Have you ever been convicted of a felony? If yes, explain:	Yes	No
Are you excluded from participating in any State or Federal health Program?	Yes	No
Have you ever been a subject of or party to a State or Federal Fraud or Abuse investigation? If Yes, Explain:	Yes	No
Have you had a finding entered into the State Nurses Aide registry concerning abuse, neglect, or mistreatment of Residents or misappropriation of their property? If Yes, Explain:	Yes	No

Application for Employment

Education

Institute	Name & Address	Course of Study	Years Completed	Diploma/Degree
High School				
Undergraduate/College				
Graduate/Professional				
Other (Specify)				

Indicate any foreign languages you can speak/read or write: ____

Describe any specialized training, licenses, certifications, apprenticeship, skills and extra-curricular activities you have had.

____

____

____

Summarize special-job related skills and qualifications acquired from employment or other experience you have

____

____

____

____

Specialized Skills

☐ **Microsoft Office (Excel, Word, etc.)** ☐ **Office Equipment** ☐ **Customer Service** ☐ **Phone Systems**

☐ **Mechanical Lifts** ☐ **Electronic Charting** ☐ ____________________________________

☐ ____________________________________ ☐ ____________________________________

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Employment Experience Please start with your present or last job.

1. Employer Name	**Job Title**	**Dates To - From**	
Employer Address			
Supervisors Name		**Employer Phone**	
Work Performed		**Reason for Leaving**	
2. Employer Name	**Job Title**	**Dates To - From**	
Employer Address			
Supervisors Name		**Employer Phone**	
Work Performed		**Reason for Leaving**	
3. Employer Name	**Job Title**	**Dates To - From**	
Employer Address			
Supervisors Name		**Employer Phone**	
Work Performed		**Reason for Leaving**	
4. Employer Name	**Job Title**	**Dates To - From**	
Employer Address			
Supervisors Name		**Employer Phone**	
Work Performed		**Reason for Leaving**	

References

First & Last Name	Contact Number	Affiliation?	How long?
EXAMPLE(s): Jane Doe *Fred Flintstone*	*207-123-4569* *207-456-7891*	*Supervisor* *Friend*	*2 Yrs* *7 Yrs*
1.			
2.			
3.			

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Applicant's Statement

I certify that answers given herein are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

I do hereby authorize all my previous employers or references to furnish any information concerning my personal character, habits or employment records. I hereby release all such persons from liability or damages incurred as a result of inquiry and furnishing this information.

This application for employment shall be considered active for a period of time not to exceed 45 days (but will be retained for one year). Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at that time.

I hereby understand and acknowledge that any employment relationship with this organization is of an "at will" nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause. It is further understood that this "at will" employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

I understand that false or misleading information or omissions given in my application or interview (s) may result in a decision not to hire me, or immediate discharge if discovered after I am hired. I understand, also that I am required to abide by all rules and regulations of the Employer.

Signature of Applicant Date

FOR PERSONNEL DEPARTMENT USE ONLY		
Date	**Interviewer**	
Remarks		
Employed Yes No	**Date of Employment**	
Department	**Job Title**	**Hourly Rate/Salary**
By		**Date**

First Atlantic HealthCare

Application for Employment

Applicant Self-Identification Form

Applicants are considered for all positions without regard to race, color, sex, national origin, veteran status, or disability status. As an Affirmative Action/Equal Opportunity employer, First Atlantic Health Care complies with government regulations and affirmative action responsibilities.

Please complete the Applicant Self-Identification Form to assist us with government record keeping, reporting, and other legal requirements. The data is for analysis and affirmative action purposes. **Submission of information is voluntary and refusal to provide it will not subject you to any adverse treatment.** The information will be kept confidential and will only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual. **Completion of information below is voluntary.** Thank you for your cooperation.

Name ____

Last First Middle

Position(s) Applied For: ____

Gender: ☐ Male ☐ Female

Race/Ethnic Group (Please check all that apply):

- ☐ **Hispanic or Latino** *A person of Cuban, Mexican, Chicano, Puerto Rican, South or Central American or other Spanish culture or origin , regardless of race.*
- ☐ **American Indian or Alaskan Native**:*A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.*
- ☐ **Asian**: *A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, & Vietnam.*
- ☐ **Black or African American**: *A person having origins in any of the black racial groups of Africa.*
- ☐ **Native Hawaiian or Pacific Islander:** *A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.*
- ☐ **White or Caucasian**: *A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.*
- ☐ **Two or More Races**: *A person who primarily identifies with two or more of the above race/ethnicity categories.*
- ☐ **I prefer not to answer.**

____ ________________

Signature **Date**

If you should have any questions regarding this form, please contact Human Resources.

Applicant Self-Identification Form

Name: ___________________________________

This employer is a Government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA), which requires Government contractors to take affirmative action to employ and advance in employment: (1) disabled veterans; (2) recently separated veterans; (3) active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans. These classifications are defined as follows:

- A "**disabled veteran**" is one of the following:
  - a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or
  - a person who was discharged or released from active duty because of a service-connected disability.
- A "**recently separated veteran**" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.
- An "**active duty wartime or campaign badge veteran**" means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.
- An "**Armed forces service medal veteran**" means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

Protected veterans may have additional rights under USERRA—the Uniformed Services Employment and Reemployment Rights Act. In particular, if you were absent from employment in order to perform service in the uniformed service, you may be entitled to be reemployed by your employer in the position you would have obtained with reasonable certainty if not for the absence due to service. For more information, call the U.S. Department of Labor's Veterans Employment and Training Service (VETS), toll-free, at 1-866-4-USA-DOL.

If you believe you belong to any of the categories of protected veterans listed above, please indicate by checking the appropriate box below. As a Government contractor subject to VEVRAA, we request this information in order to measure the effectiveness of the outreach and positive recruitment efforts we undertake pursuant to VEVRAA.

I IDENTIFY AS ONE OR MORE OF THE CLASSIFICATIONS OF PROTECTED VETERAN LISTED ABOVE

I AM NOT A PROTECTED VETERAN

I PREFER NOT TO ANSWER

Submission of this information is **voluntary** and refusal to provide it will not subject you to any adverse treatment. The information provided will be maintained confidentially and used only in ways that are not inconsistent with the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended.

First Atlantic HealthCare

Application for Employment

Voluntary Self-Identification of Disability

Form CC-305 OMB
Control Number 1250-
0005 Expires 1/31/2020

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.[i] To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

Please check one of the boxes below:

☐ YES, I HAVE A DISABILITY (or previously had a disability)

☐ NO, I DON'T HAVE A DISABILITY

☐ I DON'T WISH TO ANSWER

______________________________ Your Name

______________________ Today's Date

Voluntary Self-Identification of Disability

Form CC-305 OMB Control Number 1250-0005 Expires 1/31/2020

Reasonable Accommodation Notice

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

i Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.