

**EMPLOYMENT APPLICATION FOR:**

- Butler Hospital
- Kent Hospital
- Women & Infants Hospital
- CNE Home Health
- CNE Wellness Center
- Care New England
- Other \_\_\_\_\_

# CARE NEW ENGLAND

BUTLER HOSPITAL • KENT HOSPITAL • WOMEN & INFANTS HOSPITAL  
 VNA of CARE NEW ENGLAND • CNE WELLNESS CENTER  
 www.carenewengland.org

We are proud to provide Equal Employment Opportunities to all qualified applicants and employees irrespective of race, color, national origin, sex, gender identity or expression, religion, age, disability or veteran status.

**All information must be completed even if resume is attached - Please Print**

<b>Official Use Only:</b>	
Appointment: _____	
Date: _____	Time: _____

DATE \_\_\_\_\_

## PERSONAL

NAME \_\_\_\_\_ Home Tel. No. \_\_\_\_\_  
Last First Middle

ADDRESS \_\_\_\_\_ Daytime Tel. No. \_\_\_\_\_  
Street City State Zip

Have you ever worked under a different name?  Yes  No (If yes, list name) \_\_\_\_\_ Email Address \_\_\_\_\_

Position(s) Applied For: \_\_\_\_\_

Dept./Unit Preference: \_\_\_\_\_

(Minimum Salary Requirement \_\_\_\_\_ per week/year.)

Available for (Check any or all)

- Full Time
- Days
- Weekends
- Part Time Min Hrs. \_\_\_\_\_
- Evenings
- Summer
- Per Diem (on call)
- Nights
- Temporary

**If experienced, please mark appropriate boxes**

- Typing speed \_\_\_\_\_ WPM \_\_\_\_\_
- Dictaphone  Yes  No
- Shorthand/Speedwriting  Yes  No
- Medical Terminology  Yes  No
- Computer Software Experience:
  - Access  Power Point  Excel  Word
  - Other: \_\_\_\_\_

## EDUCATION AND TRAINING

Schools	Name and Address	No. Years	Pres. Grade	Grad-uated?	Type of Degree	Major Courses
High/Prep School or GED	_____					
	_____					
College/ University/ Nsg. School	_____					
	_____					
Graduate Study	_____					
	_____					
Business or Vocational	_____					
	_____					

**Professional & Occupational Licensure**

Are you now licensed or registered in your profession or occupation?  Yes  No

In Rhode Island?  Yes  No

R.I. Licensure or Registration # \_\_\_\_\_  
 Expiration Date \_\_\_\_\_

State and Date where original license or registration was issued: \_\_\_\_\_

If not licensed or registered in Rhode Island, have you made application?  Yes  No  
 Explain \_\_\_\_\_

Has your license to practice your profession ever been suspended or revoked?  Yes  No  
 Explain \_\_\_\_\_

**List any certification:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Other formal training (include Military Service – experience)

List professional associations of which you are a member. (State & National Societies, Professional Clubs, Etc.)

Describe any other skills, experience, or qualifications you have

• Have you ever worked/volunteered at any CNE Organization? If so, list: \_\_\_\_\_ Dates: \_\_\_\_\_

• Have you ever been sentenced or convicted for any violation of the law?  Yes  No If yes, when and for what charge? \_\_\_\_\_  
 A "yes" will not be an absolute bar to employment.

• Have you ever been or are you now barred from participation in any government health care programs including Medicare, Medicaid, or Champus?  Yes  No If yes, explain: \_\_\_\_\_

• Referral Source:  Ad  Walk-In  Person  Agency  Web Please Specify \_\_\_\_\_

**WORK EXPERIENCE**

List most recent employment first

Name and Address of Employer	Employment Dates		Positions Held	Description of Duties	Reason for Leaving
	From Mo. / Yr.	To Mo. / Yr.			
	Salary				
Supervisor: _____	Tel. No. _____				
	From Mo. / Yr.	To Mo. / Yr.			
	Salary				
Supervisor: _____	Tel. No. _____				
	From Mo. / Yr.	To Mo. / Yr.			
	Salary				
Supervisor: _____	Tel. No. _____				
	From Mo. / Yr.	To Mo. / Yr.			
	Salary				
Supervisor: _____	Tel. No. _____				

**LIST OTHER PROFESSIONAL REFERENCES**

Name	Relationship / Occupation	Address	Phone No.	Years Known
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1. \_\_\_\_\_
2. \_\_\_\_\_

I hereby certify that the answers given by me to the foregoing questions and the statements made by me are full and true to the best of my knowledge and belief. I understand that any false information, omissions, or misrepresentations of facts called for in this application or any supplements thereto, is cause for rejection of my application or discharge at any time during my employment. I understand that as a condition of employment I will be required to complete the organization's pre-employment physical examination and background checks. I understand that any offer of employment is contingent on my producing appropriate documentation verifying my identity and employment authorization, as required under the Immigration Reform and Control Act. I understand that my employment is terminable at-will, that I am not being employed for any specified time, and that this application is not and is not intended to be a contract for continued employment. If I am employed, I agree to abide by and observe all rules and regulations of the hospital. I voluntarily authorize my former employers, schools and persons named herein to give information regarding me, whether or not such information is part of their records. I hereby release said organizations or persons from any liability or damages whatsoever for issuing this information.

May we contact your present employer?  Yes  No If not, why \_\_\_\_\_

\_\_\_\_\_  
**Applicant's Signature** **Date**