LUMEN CHRISTI HEALTH CARE INC

1359 Hancock ST Suite 6 * North Quincy MA, 02169 * Tel: (617) 479-0206 * Fax: (617) 479-0348

lumen.christi.hci@gmail.com

EMPLOYMENT APPLICATION

General Information

Please print in black ink only!

Name: Last	Name: First
Social security number	Name: Middle
Current Address: Street	Daytime Telephone
City State Zip code	Home telephone

Position(S) desired

1).
2).
3).

Date of availability	***Preferred Work Schedule***
...../...../.....	□***Day*** □***Evening*** □***Night***

Are you permitted to work in the United States? ◯ Yes or ◯ No

Are you permitted to work only for a particular employer? ◯ Yes or ◯ No

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EDUCATION

	Completed (Y/N)	Major	From: Mo/Yr	To: Mo/Yr	Degree received
High School/Equivalent					
Additional Education					

PROFESSION

Professional Licenses/Registration(s) /Certifications	State	Number	Yr. Received	Date of Expiration

Professional Associations	

EMPLOYMENT HISTORY

1. **Employer's Name:** _____

	From	**To**
Time employed		
Supervisor's Name		
Position Responsibilities		
Reason for Leaving		

2. **Employer's Name:** _____

	From	**To**
Time employed		
Supervisor's Name		
Position Responsibilities		
Reason for Leaving		

3. **Employer's Name:** _____

	From	**To**
Time employed		
Supervisor's Name		
Position Responsibilities		
Reason for Leaving		

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CERTIFICATION

I certify that the information on this employment application is true and complete to the best of my knowledge, I understand that any misrepresentation, willful omission, false or misleading information is grounds for rejection of this application form, refusal to hire, withdrawal of an offer of Employment, or immediate discharge whenever discovered. You are authorized to conduct investigations, including verification of prior employment history and education. I also understand that employment is dependent upon receipt of acceptable employment history and satisfactory completion of a pre-employment health screening which will include illicit drug or alcohol testing and provision of documents required by the immigration reform and control Act of 1986. Lumen Christi Health Care inc. does not discriminate against any qualified person because of age, race, color, religion, sex, national origin, disability or sexual orientation. By signing this application, I acknowledge that an offer of employment at Lumen Christi Health Care inc. should not be interpreted as an offer of continued or permanent employment.

_____ _____/_____/_____

Signature **Date**

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REQUEST FOR REFERENCE

Applicant Name: .....

Employed from: ..... to: .....

Position/title: .....

Reason for leaving: .....

I, ...*Applicant*....., hereby authorize and request my former/current employer/person given as a reference herein to answer all questions asked, and give all information requested concerning my character, work performance, and job related skills.

To: .....*Referee*.....Tel .....

Address: .....

City: ..... State: ..... Zip Code.....

For The Referee

(Applicant do not write beyond this line)

The above named applicant has applied for a position with Lumen Christi Health Care inc. and has given your name as a previous or current employer. Please complete this reference request and Mail or fax it to us. Thank you for your prompt reply.

	Excellent	Above average	Average	Unsatisfactory(comment)
Quality of work				
Time and attendance				
Initiative/motivation				
Relationship with coworker/supervisor				
Job knowledge				

Would you rehire this person? Yes.....No.....

If no, why? .....

Other comments: .....

Date: .....Phone Number .....

Supervisor's signature.....

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Time and attendance				
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Would you rehire this person? Yes.....No.....

If no, why? .....

Other comments: .....

Date: .....Phone Number .....

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DRUG AND ALCOHOL POLICY AGREEMENT

It is the policy of **Lumen Christi Health Care Inc**. that all its employees be free of the influence of alcohol and drugs. All employees must be fit for the duty: physically and mentally, as is necessary to perform work in a safe and competent manner.

Possession, trading, manufacture and sale of illegal drugs or alcohol on the job are therefore a violation of this policy.

Also, it is a violation of this policy to work under the influence of illegal drugs or alcohol.

Violations of this policy are subject to disciplinary action up to and including termination.

ACKNOLEDGEMENT

I, ……, certify that I am not under the influence of drugs or alcohol, nor will I use or possess in anyway controlled substances (marijuana, heroin, cocaine, crack, hash etc). I understand that these examples do not cover all controlled substances. Failure to comply with this agreement may result in termination of my employment with Lumen Christi Health Care inc. I have been briefed and fully understand Lumen Christi Health Care inc. drug and alcohol policy and I agree to fully comply with the provisions herein.

…… ……

Employee Signature Date

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PERFORMANCE EVALUATION

PROBATIONARY □ ANNUAL □

APPLICANT'S NAME: ……

SOCIAL SECURITY NUMBER: ……

POSITION HELD …… DATE OF HIRE: ……

FROM: …… TO: ……

PERSONAL EVALUATION	ABOVE AVERAGE	SATISFACTORY	NEEDS IMPROVEMENT	POOR
Quality of work				
Interest and Enthusiasm				
Ability to relate Patient				
Ability to relate to Staff				
Adaptability to Change				
Ability to handle Stress				
Willingness/ Ability To float				
Attendance				
Punctuality				
Personal appearance				
Documentation				
Follows plan of care for patient				

Comments:

……

……

……

……

……

Employee Signature: …… Date: ……

Representative/DON: …… Date: ……

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HEPATITIS B VACCINE DECLINATION FORM

I, ……, understand that due to the occupational exposure of blood or other potential infectious materials, I may be at risk of acquiring Hepatitis B (HBV) infection. I have been informed about the importance of being vaccinated against Hepatitis B. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If in future I want to be vaccinated against Hepatitis B, arrangements will be made for me to acquire the vaccine.

Employee's Name (print): ……

Signature: …… …… Date: ……

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EMPLOYMENT STATEMENT OF CONFIDENTIALITY

I, the undersigned, understand the importance of observing strict confidentiality policies. Therefore, I agree not to discuss / release any information obtained within the agency, any Lumen Christi Health Care inc. client , their medical records, or any client's condition with any individual not directly associated with Lumen Christi Health Care inc., nor with Lumen Christi Health Care inc. employee who are not directly associated with the client. I also agree that any information that is released regarding the client or the client's record will only be done with proper authorization and /or in accordance with established agency policy for the release of the information.

My signature on this document indicates that I understand and agree to abide by the aforementioned policies, and that any breach in the aforementioned policies will result in implementation of the Disciplinary procedure up to and including possible IMMEDIATE DISMISSAL from employment at Lumen Christi Health Care inc.

…… ……

Employee's Signature Date

…… ……

Supervisor's Signature Date

NB: To Submit, click the submit button below and follow the steps OR save this file on your desktop, fill it out and then email it to Lumen.Christi.Hci@gmail.com.

Submit Form