



Are you legally eligible for employment in this country?  Yes  No  
 You will be required to present evidence of legal authorization to work in the United States, if you are extended a job offer in accordance with the Immigration and Reform Control Act.

Have you ever been suspended, sanctioned or otherwise restricted from participating in any private insurance entity or Federal or State health insurance program(i.e. Medicare, Medicaid)?  Yes  No

While the Manor does not require or request of it's employees to take a lie detector test, State Law requires the following notice: 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.

**EDUCATION AND TRAINING**

	Name of Institution	Dates Attended	Did you graduate	Degree or Diploma
High School				
College				
Nursing School, Technical School				
Other				

**PERSONAL REFERENCES**

Please provide the names, addresses, and telephone numbers of two (2) individuals who are not relatives or previous employers who we may contact for reference information.

Name: \_\_\_\_\_ Years known: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone # \_\_\_\_\_

Name: \_\_\_\_\_ Years known: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone # \_\_\_\_\_

**EMPLOYMENT HISTORY**

Please provide the information requested for all previous employers starting with the most recent:

**# 1 Employer's Name:** \_\_\_\_\_

Address: \_\_\_\_\_  
 Street City/Town State Zip Code

Phone #: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_  
 From Month/Day/Year to Month/Day/Year

Position Held: \_\_\_\_\_

Describe your responsibilities: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

**# 2 Employer's Name:** \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/Town State Zip Code

Phone #: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_  
From Month/Day/Year to Month/Day/Year

Position Held: \_\_\_\_\_

Describe your responsibilities: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

**# 3 Employer's Name:** \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/Town State Zip Code

Phone #: \_\_\_\_\_

Dates of Employment: \_\_\_\_\_  
From Month/Day/Year to Month/Day/Year

Position Held: \_\_\_\_\_

Describe your responsibilities: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_

Reason for leaving: \_\_\_\_\_

Please include any other information that you think would be helpful to use in considering you for employment, such as additional work experience, skills, activities, accomplishments, experience acquired in the US Armed Services, etc. (Please exclude information that would reveal sex, race, religion, national origin, age, color, disability or other protected status)

---

---

---

---

---

---

---

---

**PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

I understand and agree that prior to any job offer, I will be given a written description of that job and will be asked about my ability to perform specific job functions or duties involved in that job.

I understand and agree that any job offer is conditional and will be contingent upon satisfactory results of post offer medical examination and medical clearance establishing that I am capable of performing the job offered with or without reasonable accommodation.

I understand and agree that any job offer is conditional and contingent upon satisfactory verification by the employer of the information that I have furnished in this application.

I hereby grant the Manor permission to verify the accuracy and completeness of this information and to investigate all references and educational records. I agree to absolve from any liability the Manor and any other individual and/or employer who provides the information necessary to verify the information provided in this application. I understand that any false representation, misrepresentations, or misleading statements made by me in this application or in connection with my physical condition and medical examination will be grounds for the rejections of this application or for my dismissal.

I understand and agree that if my application is accepted, my employment may be terminated by me or by this facility at any time, with or without cause and without any liability on the part of the facility for future wages, salary or benefits. I further understand that if accepted, my employment is at will and for no definite period and I may be terminated without further notice and without liability for further salary. I understand that any representations made by the employer with the applicant's employment must be made in writing by an authorized officer of the facility.

I also understand that a criminal record check will be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me.

I certify that the statements I have made and furnished in this application are true.

I represent and warrant that I have read and fully understand the foregoing and seek employment under these conditions.

---

Applicant's Signature

---

Today's Date

**St. Joseph Manor  
Reference Check Form**

APPLICANT: Please complete this section so that we may contact previous employers to obtain a reference check.

Your name: \_\_\_\_\_

*In order to ensure the safety of the residents, Massachusetts Department of Public Health (DPH) regulations require close examination of an applicants references prior to hiring (105 CMR 155.010 (G)(2) ) and cooperation with other facilities and health care agencies in providing information to prospective employers about an applicants competence, including the ability to handle patients or residents with difficult behavioral problems (105 CMR 155.010 (G) (4) ). Merely providing a potential employer with the date and length of employment is insufficient and does not meet regulatory requirements. Under Massachusetts law, a nursing facility, home health agency or hospice program is not liable for disclosing information during the course of providing employee references (M.G.L. Ch. 111:72L ½). For more information, please contact Mass Senior Care President for Labor and Workforces Development Carolyn Blanks.*

**Reference #1**

You were/are employed by: \_\_\_\_\_  
Address of employer: \_\_\_\_\_  
Phone # of employer: \_\_\_\_\_  
You were employed from: \_\_\_\_\_ to \_\_\_\_\_  
The position you held: \_\_\_\_\_

Employer Comments:

To be completed, signed & dated by Manor Associate obtaining reference check.


**Reference #2**

You were/are employed by: \_\_\_\_\_  
Address of employer: \_\_\_\_\_  
Phone # of employer: \_\_\_\_\_  
You were employed from: \_\_\_\_\_ to \_\_\_\_\_  
The position you held: \_\_\_\_\_

Employer Comments:

To be completed, signed & dated by Manor Associate obtaining reference check.


I authorize my former employers to provide reference, and hereby release them from all liability. I understand that this information will remain confidential.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# ST. JOSEPH MANOR

WHERE HEARTS ARE FULL AND LOVE IS OVERFLOWING

[XSTJMN]  
CH336  
\$15.00

## CORI REQUEST FORM DIRECT CARE

St. Joseph Manor has been certified by the Criminal History Systems Board for access to Criminal Offender Record Information (CORI) on applicants, who are under final consideration for, or individuals currently employed in, positions that involve the provision of direct personal care or treatment to residents.

St. Joseph Manor is requesting all the available criminal offender record information (CORI) on the below named individual from the Criminal History Systems Board pursuant to M.G.L. c 6 § 172E which mandates that long term care facilities complete background checks on current or prospective employees who will provide care and treatment to residents of said facility.

### **Volunteer/Employee Information (Please Print)**

Last Name :	First Name :	Middle Name :
Maiden Name or Alias :	Place of Birth :	Date of Birth :
Social Security # (requested but not required) :	ID Theft Index PIN (If Applicable) :	Mother's Maiden Name :
Current Address :		
Former Address :		

Sex :	Height :	Weight :	Eye Color :
State Driver's License # :			

To be completed by St. Joseph Manor CORI Authorized Individual:

**The above information was verified by reviewing and maintaining a copy of the following form of government issued photographic identification :**

Requested by : \_\_\_\_\_  
Kelly M. Ethier or Anne M. DeMinico (CORI Authorized Individuals)

*The CHSB Identity 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*



# ST. JOSEPH MANOR

WHERE HEARTS ARE FULL AND LOVE IS OVERFLOWING

## Associate Physical Form

Name : \_\_\_\_\_ Date of Birth : \_\_\_\_\_  
Position : \_\_\_\_\_ Today's Date : \_\_\_\_\_

**THIS FORM IS TO BE COMPLETED BY YOUR PHYSICIAN PRIOR TO EMPLOYMENT  
AND / OR EVERY OTHER YEAR**

Body Part	Comments
Back	
Neck	
Shoulder(s)	
Elbow(s)	
Wrist(s)	
Hand(s)	
Knee(s)	
Ankle(s)	
Eyes	
Skin	
Heart	
Lungs	
Abdomen	
Hernia	
Diabetes	

Blood Pressure : \_\_\_\_\_ Pulse : \_\_\_\_\_ Height : \_\_\_\_\_ Weight : \_\_\_\_\_

### EMPLOYMENT MEDICAL RATING

Can perform essential functions of the job ?  Yes  No

If no, please explain why :


Can perform the essential functions of the job with the following accommodations :


Additional Comments :


Date : \_\_\_\_\_ Examining Physician : \_\_\_\_\_