Chriswell

# Employment Application

## Direct Support Professional (DSP)

Chriswell Healthcare Services LLC appreciates your interest in pursuing employment as a Direct Support Professional (DSP). Applicants are requested to complete each section of this application accurately and in its entirety. Applications submitted with missing or incomplete information may not be considered for further review.

Fields marked with * are required and must be completed prior to submission.

**How to complete and return this application**

Fill it in on a computer or print it and write clearly in ink. Return it in person or by mail to Chriswell Healthcare Services LLC, 2365 NJ-33, Robbinsville, NJ 08691, or email it to careers@chriswellhealth.com. You can also apply online at chriswellhealth.com/careers. This application is for DSP positions only.

## POSITION APPLIED FOR

Location/program (check all that apply) *

- ☐ Mercer County
- ☐ Burlington County
- ☐ Camden County
- ☐ Somerset County
- ☐ Middlesex County
- ☐ Open to the full service area

Desired employment type

- ☐ Full-time
- ☐ Part-time
- ☐ PRN/Relief
- ☐ Per diem

Date available to start

How did you hear about us?

## APPLICANT INFORMATION

We do not ask for your Social Security number, date of birth, or driver's license number on this form. We collect them in person when you are hired.

Legal first name *

Middle name

Last name *

Street address *

Apt/Floor

City *

State *

ZIP *

Phone (mobile) *

Phone (alternate)

Email *

Other names used in your present or past work experience

Are you at least 18 years of age? * ☐ Yes ☐ No

Are you legally authorized to work in the U.S.? * ☐ Yes ☐ No

Have you previously worked for Chriswell? * ☐ Yes ☐ No

## AVAILABILITY

Check every shift you can work. Select at least one.

| Shift | Mon | Tue | Wed | Thu | Fri | Sat | Sun |
|---|---|---|---|---|---|---|---|
| Day shift | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Evening shift | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Overnight shift | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Weekend/on-call | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

☐ I can work holidays

_____

Maximum hours per week

## EDUCATION

Complete at least one row.

| | School name & location | Years attended | Diploma/degree |
|---|---|---|---|
| HIGH SCHOOL | | | |
| TRAINING PROGRAM | | | |
| COLLEGE/UNIVERSITY | | | |
| OTHER | | | |

## DSP EXPERIENCE

Years supporting people with intellectual and developmental disabilities *

☐ None ☐ Less than 1 year ☐ 1 to 2 years ☐ 3 to 5 years ☐ More than 5 years

Settings you have worked in (check all that apply)

☐ In-home supports ☐ Community-based supports ☐ Day program

☐ Group home or residential ☐ Supported employment ☐ Other: _____

Supports you have provided (check all that apply)

☐ Personal care ☐ Medication administration ☐ Behavioral supports

☐ Community outings and transportation ☐ Meal preparation ☐ Job coaching

☐ Communication supports ☐ Other: _____

Describe your experience supporting people with disabilities. *

Why do you want to work as a DSP? *

Languages spoken

## TRAINING AND CERTIFICATIONS

Not required to apply. Required training is provided after hire. Check any you have already completed.

- ☐ CPR/First Aid
- ☐ Danielle's Law training
- ☐ Other: _____
- ☐ College of Direct Support (CDS) modules
- ☐ Medication administration certification

## DRIVING AND TRANSPORTATION

We collect your license number in person for the driving record check.

Do you have a valid driver's license? * ☐ Yes ☐ No

If yes, issuing state

Years licensed

Do you have access to a reliable, insured vehicle? * ☐ Yes ☐ No

Are you willing to transport the people you support? * ☐ Yes ☐ No

## EMPLOYMENT HISTORY

Begin with your most recent employer. List up to five. Do not include pay history.

☐ I have no prior work history

### EMPLOYER 1

Employer name *
Phone
Address *
Immediate supervisor
Job title *
Dates employed: from *
Dates employed: to *
Reason for leaving *
Duties/responsibilities

### EMPLOYER 2

Employer name *
Phone
Address *
Immediate supervisor
Job title *
Dates employed: from *
Dates employed: to *
Reason for leaving *
Duties/responsibilities

### EMPLOYER 3

Employer name *
Phone
Address *
Immediate supervisor
Job title *
Dates employed: from *
Dates employed: to *
Reason for leaving *
Duties/responsibilities

**EMPLOYER 4**

Employer name *

Phone

Address *

Immediate supervisor

Job title *

Dates employed: from *

Dates employed: to *

Reason for leaving *

Duties/responsibilities

**EMPLOYER 5**

Employer name *

Phone

Address *

Immediate supervisor

Job title *

Dates employed: from *

Dates employed: to *

Reason for leaving *

Duties/responsibilities

Please explain any gaps in employment and your reason for leaving each employer. *

## PROFESSIONAL REFERENCES

Please provide three professional references, unrelated to the applicant, who can attest to your work performance.

| Name * | Relationship * | Address * | Phone * | Years known * |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## BACKGROUND CHECKS AND CONSENT

These checks are required by the NJ Division of Developmental Disabilities for anyone providing direct support. Check each box to consent. *

- ☐ I understand that employment requires a State and Federal criminal history background check through fingerprinting, and I consent to it.
- ☐ I consent to a check of the New Jersey Central Registry of Offenders Against Individuals with Developmental Disabilities.
- ☐ I consent to a Child Abuse Record Information (CARI) check through the NJ Department of Children and Families.
- ☐ I consent to pre-employment drug testing and to random drug testing during employment.
- ☐ If my role includes driving, I authorize Chriswell Healthcare Services LLC to request my Motor Vehicle Record (MVR) from the motor vehicle agency of any state where I have held a license, before hire and periodically during employment.
- ☐ I understand that before starting work I must provide a statement from a licensed physician or advanced practice nurse that I am in good health, based on an exam within the past 12 months.

## DATA PRIVACY NOTICE

The information you provide in this application is used only to evaluate your qualifications for employment and to meet state and federal hiring and compliance requirements. Chriswell Healthcare Services LLC keeps it secure, limits access to the staff involved in recruitment, credentialing, and compliance, and retains it as required by applicable record-keeping laws. Your information is never sold or shared with third parties outside the hiring and compliance process. Voluntary self-identification (EEO) answers are kept separate from your application. You may request access to or correction of your information by contacting us at careers@chriswellhealth.com.

## APPLICANT STATEMENT AND SIGNATURE

### PLEASE READ BEFORE SIGNING

My signature verifies that information provided in this application is true and complete. I understand the agency is an Equal Opportunity Employer. I understand that falsification, including withholding of information, on this application is grounds for immediate dismissal if I am selected for a position. I further understand that if I am hired, I can be terminated, with or without cause and with or without notice. I agree to have my picture taken for identification purposes and to submit to drug screening tests, upon request. I understand that all references listed above may be contacted in addition to past employers and educational institutions.

**I, _____ (applicant), hereby authorize Chriswell Healthcare Services LLC to request and receive from all prior employers within one (1) year of the date of this application, any and all pertinent information concerning my prior employment and its termination, including the reasons for such termination.**

I certify that the information provided in this application is true, complete, and accurate to the best of my knowledge. I understand that any misrepresentation or omission of fact may result in rejection of this application or, if discovered following commencement of employment, termination of employment. I acknowledge that this position may require lifting, transferring, and assisting clients with activities of daily living. I understand that submission of this application does not constitute an offer or guarantee of employment.

| Applicant signature * | Printed full legal name * | Date * |
|---|---|---|
| | | |

### FOR OFFICE USE ONLY

| | | | |
|---|---|---|---|
| Date received | | Interviewed by | |
| Central Registry checked | | CARI submitted | |
| Fingerprinting date | | MVR received | |
| Drug test date | | Hire decision | |

## VOLUNTARY SELF-IDENTIFICATION (EEO)

Completion of this page is voluntary and will not affect consideration of your application. Please detach this page and return it separately or in a sealed envelope. It is kept apart from your application and used only for equal opportunity compliance reporting.

Name (optional) _____ Date _____

Gender

☐ Male ☐ Female ☐ Decline to state

Race/ethnicity

☐ Hispanic or Latino
☐ White (not Hispanic or Latino)
☐ Black or African American (not Hispanic or Latino)
☐ Asian (not Hispanic or Latino)
☐ Native Hawaiian or Other Pacific Islander (not Hispanic or Latino)
☐ American Indian or Alaska Native (not Hispanic or Latino)
☐ Two or more races (not Hispanic or Latino)
☐ Decline to state

Veteran status

☐ Protected veteran ☐ Not a protected veteran ☐ Decline to state

Disability status

☐ Yes, I have a disability (or previously had one)
☐ No, I do not have a disability
☐ Decline to state