Chriswell

Employment Application

All positions except Direct Support Professional

Chriswell Healthcare Services LLC appreciates your interest in pursuing employment as a member of our care team. 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. Direct Support Professionals use the separate DSP application.

POSITION APPLIED FOR

Position title (check one) *

- ☐ Certified Home Health Aide (CHHA)
- ☐ Registered Nurse (RN)
- ☐ Licensed Practical Nurse (LPN)
- ☐ Recruiter/Scheduler
- ☐ Companion Caregiver
- ☐ Care Coordinator
- ☐ Other: _____

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

Desired hourly wage

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	☐	☐	☐	☐	☐	☐	☐

Maximum hours per week

Do you have reliable transportation? * ☐ Yes ☐ No

Are you willing to work with multiple clients/sites? * ☐ Yes ☐ No

EDUCATION

Complete at least one row.

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

LICENSURE & CERTIFICATION

Required for CHHA, RN, and LPN applicants (at least one). Optional for other positions.

Type	Issuing authority	Number	Expiration date

MALPRACTICE INSURANCE

RN, LPN, and Care Coordinator applicants only. Complete if you carry individual professional liability (malpractice) insurance.

Carrier name

Carrier address

Policy number

Expiration date

DRIVER'S LICENSE & VEHICLE INFORMATION

This position may require travel between client homes and care sites. We collect your license number in person.

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

If yes, issuing state

If yes: Do you have current auto insurance? ☐ Yes ☐ No

If yes: Are you willing to use your personal vehicle for client visits? ☐ Yes ☐ No

If yes: Any moving violations in the past 3 years? ☐ 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

EXPERIENCE AND QUALIFICATIONS

Please list any and all areas of actual working experience and how long you worked in each (for example: home care, one year; ICU, one year; med-surg). *

Please explain, in detail, any periods of unemployment and your reason for leaving each employer. *

Why are you interested in this position? *

What special qualifications do you have that would help in this position (for example, a language you speak or computer programs you know)?

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 CHECK & CONSENT

As a condition of employment, Chriswell Healthcare Services LLC conducts criminal background checks, state abuse and neglect registry checks, licensure or certification verification, and checks of federal and state exclusion lists. By signing below, you authorize us to obtain this information for employment purposes.

☐ I authorize Chriswell Healthcare Services LLC to conduct a criminal background check, registry checks, licensure or certification verification, exclusion list checks, and reference verification. *

☐ If I hold a driver's license, I authorize Chriswell Healthcare Services LLC to request my Motor Vehicle Record (MVR) before hire and periodically during employment.

CHHA, RN, and LPN applicants: Has your license or certification ever been suspended, revoked, or disciplined? ☐ Yes ☐ No

If yes, please explain

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 _____

License verified _____ 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