Guide To Filling Out Your Application

Dear Applicant:

Attached is an application for employment at Roosevelt Care Center at Edison and Roosevelt Care Center at Old Bridge. The application must be filled out completely.

1. Fill out page 2 and 3 and sign bottom of page 3.
2. The top half of the page 4 is optional. Do not fill out bottom half.
3. Page 5 "Employment/Service Verification" form must be signed with the "employee signature," in order to process you application.
4. Last page, page 6, must be checked yes or no.

After completion, either fax or drop off at the following locations:

For Edison location:
Attn: Human Resources
Roosevelt Care Center at Edison
118 Parsonage Road
Edison, NJ 08837
Fax 732-767-4077

For Old Bridge location
Attn: Human Resources
Roosevelt Care Center at Old Bridge
1133 Marlboro Road
Old Bridge, NJ 08857
Fax 732-360-9888

Thank you for your cooperation.

The Human Resource Department
Edison: 732-321-6800 ext 3727
Old Bridge: 732-360-9834

ROOSEVELT CARE CENTER

EMPLOYMENT APPLICATION

Position Applied For			Date:
Name			
Last	*First*	*MI*	
Address:			
Street	*City*	*State*	*Zip*

Home Phone:	Cell Phone:	Work Phone:

Can we call you at work? ☐ *YES* ☐ *NO*

Are you eligible to work in the USA?	☐ YES	☐ NO	*(Proof of citizenship or immigration status is required.)*		
Valid and Current Drivers License No.				State Issued	
List other professional licenses & expiration dates:					
Professional Licenses				***Expiration Date***	
Type of Employment desired.	☐ Full Time	☐ Part Time	☐ Per Diem	☐ Seasonal	☐ Shift 1, 2, 3

SCHOOL RECORD

Name and Addresses of School	No. of Years completed	Degree earned or major
1.		
2.		
3.		

REFERENCES *(Professional or personal who are not relatives)*

Name	Phone Number including area code
1.	
2.	
3.	
Are you proficient (i.e., read, speak, understand) English? ☐ YES ☐ NO	Other Languages?

EMPLOYMENT BRIEF

(List last 4 employers. Gaps in employment should be explained below in the "Additional Information" section)

Employer	*Telephone*	*Dates (From – To)*
Address	*Duties:*	
Job Title	*Reason for Leaving:*	
Supervisor		

Employer	*Telephone*	*Dates (From – To)*
Address	*Duties:*	
Job Title	*Reason for Leaving:*	
Supervisor		

Employer	*Telephone*	*Dates (From – To)*
Address	*Duties:*	
Job Title	*Reason for Leaving:*	
Supervisor		

Employer	*Telephone*	*Dates (From – To)*
Address	*Duties:*	
Job Title	*Reason for Leaving:*	
Supervisor		

ADDITIONAL INFORMATION *(List other information that you would like considered.)*

I certify that I am not subject to any employment contract or other agreement which would prevent me being hired. I certify that all information on this application is accurate and true to the best of my ability and I understand that a misrepresentation is cause for removal from the job. Also, I agree and authorize Roosevelt Care Center to verify any information on or related to this application.

Signature

Employment Application Supplement

AFFIRMATIVE ACTION *(Information is voluntary)*

This survey information is not part of your official application for employment; it is considered confidential and is not a factor in the hiring decision. The purpose of collecting this data is to comply with government regulations including those agencies involved with affirmative action.

Name _____ Title Applied For _____

Sex: ☐ Male ☐ Female

EEO ID Group: ☐ White ☐ Black (Non Hispanic) ☐ Hispanic
☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander

Veterans, DVs and individuals with disabilities may have special employment considerations or access to reasonable accommodation. If you wish to be identified as such, check the applicable block(s).

☐ Vietnam era Vet (1964-1975) ☐ DV ☐ Individual with a disability

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APPLICANT – DO NOT COMPLETE THE SECTION BELOW

LICENSE VERIFICATION RECORD

License Number _____ Type _____ Expiration Date _____

Verified By _____ Title _____ Date _____

License Number _____ Type _____ Expiration Date _____

Verified By _____ Title _____ Date _____

CITIZENSHIP OR IMMIGRATION STATUS VERIFICATION

US Department of Justice (INS) Eligibility Verified ☐ YES ☐ NO

Verified By _____ Title _____ Date _____

EMPLOYMENT/SERVICE VERIFICATION FORM

Pursuant to the Health Care Professional Responsibility and Reporting Enhancement Act (HCPRREA), (P.L. 2005, c. 83, effective October 30, 2005) which enables health care entities[1] to exchange certain information regarding health care professionals[2] and in the interest of verifying such information, this form seeks information regarding the health care professional named below. Upon inquiry from a health care entity about a current or formerly employed health care professional, health care entities must provide the following information about that health care professional (see N.J.S.A. § 26:2H-12.2c): (1) job performance as it relates to patient care based upon job performance evaluations; (2) eligibility for re-employment at the health care entity; (3) reason for separation for a formerly employed health care professional and (4) copies of any notifications and supporting documentation sent to the New Jersey Division of Consumer Affairs (DCA), the medical practitioner review panel, a professional or occupational licensing board of the DCA within seven years preceding the date of this inquiry (see N.J.S.A. §§ 26:2H-12.2a and 12.2b).

TO BE COMPLETED BY REQUESTING HEALTH CARE ENTITY

Date of Inquiry: _____

Name of Candidate: _____

Maiden Name/Other Names Used _____

Professional License or Certification Number: _____

Position Applied For: _____

Employer(Name and Location):_____

Title(s)ofPosition(s)Held:_____

Dates Employed: From: _____ To: _____

*****Applicant's Signature:_____**

TO BE COMPLETED BY FORMER/CURRENT HEALTH CARE ENTITY/EMPLOYER

SECTION I

Name of Employee: _____

Title(s) of Position(s) Held: _____ Please circle one: FT PT Per Diem

Dates Employed: From: _____ To: _____

[1]The HCPRREA defines "health care entities" as health care facilities licensed pursuant to N.J.S.A. § 26:2H-1, state and county psychiatric hospitals and developmental centers, HMOs, carriers offering managed care plans, staffing registries and home care services agencies.

[2]The HCPRREA defines "health care professionals" as individuals licensed or authorized to practice a health care profession regulated by DCA or other professional and occupational licensing boards including but not limited to physicians; podiatrists; nurses; pharmacists; physical, occupational and respiratory therapists; psychologists; psychoanalysts; social workers; audiologists and speech-language pathologists; optometrists; ophthalmic dispensers and technicians; dentists; orthotists and prosthetists; marriage and family therapists; veterinarians and chiropractors; and acupuncturists. Health care professionals also include home health aides certified by the Board of Nursing and nurse aides and personal care assistants certified by the Department of Health and Senior Services.

REASON FOR SEPARATION FROM EMPLOYMENT *(please check all that apply):*

Voluntary Reasons	**Involuntary Reasons**
____ Voluntary Resignation	**____ Involuntary Lay-Off**
____ Voluntary Relocation	**____ Involuntary Discharge for Performance**
____ Voluntary Lay-Off	**____ Involuntary Discharge for Misconduct**
____ Voluntary Resignation in Lieu of Discharge	**____ Involuntary Discharge for Attendance**
____ Abandoned Position	**____ Other *(provide description)*_____**
____ Other *(provide description)*_____	

SECTION II

For all health care professionals, please describe the healthcare professional's job performance as it relates to patient care. Job performance relates to the suitability of the healthcare professional for re-employment at the health care entity and the professional's skills and abilities as they relate to suitability for future employment at a health care entity. Any job performance information provided should be based on the professional's job performance evaluation considering those evaluations signed by the evaluator and shared with the health care professional and the professional's response to that evaluation (see N.J.S.A. § 26:2H-12.2c.) Please check the appropriate blank below regarding the healthcare professional's skills and abilities relating to patient care. *(Attach additional pages as needed).*

____ Exceeds standards ____ Meets Standards ____ Does not meet standards

Please indicate the date of last/most recent performance evaluation:_____

SECTION III

Is the health care professional eligible for re-employment by the health care entity? _Yes *or* **_No**
If "No", please provide explanation as it relates to patient care (see Section II above).

SECTION IV

During the seven (7) years preceding the date of this inquiry (see above), have you submitted any notification to the New Jersey DCA, the medical practitioner review panel or any DCA professional or occupational licensing board about this health care professional? __Yes *or* __No
If yes, please provide a copy of the notification and all supporting documentation as required by N.J.S.A.§ 26:2H-12.2c

FORM COMPLETED BY:

_____ _____
Print Name **Signature**

_____ _____
Title **Date**

Middlesex County Improvement Authority
Addendum to Employment Application

Name: _____ Date: _____

Are you related to a Middlesex County Freeholder, County Clerk, Sheriff, Surrogate, Department Head, Division Head, Board Member of a County Authority or an Executive Director as a:

Spouse	_____Yes	_____No
Child	_____Yes	_____No
Parent	_____Yes	_____No
Step Child	_____Yes	_____No
In-Law	_____Yes	_____No
Sibling	_____Yes	_____No
Nephew	_____Yes	_____No
Niece	_____Yes	_____No
First Cousin	_____Yes	_____No

If yes, County Official(s) Name and Title