

REFERENCES

GIVE BELOW THREE PERSONS NOT RELATED TO YOU

	NAME	ADDRESS	TELEPHONE #	YEARS AQAUNITED WITH YOU
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

FORMER EMPLOYERS

LIST BELOW YOUR WORK EXPERIENCE, STATRING WITH YOUR PRESENT OR LAST PLACE OF EMPLOYMENT

DATES EMPLOYED	NAME & ADDRESS OF EMPLOYER	NAME OF SUPERVISOR	POSITION & SALARY	REASON FOR LEAVING
FROM _____	_____	_____	_____	_____
TO _____	_____	PHONE # _____	_____	_____
FROM _____	_____	_____	_____	_____
TO _____	_____	PHONE # _____	_____	_____
FROM _____	_____	_____	_____	_____
TO _____	_____	PHONE # _____	_____	_____

MAY WE CONTACT YOUR PRESENT EMPLOYER AT THIS TIME? YES _____ NO _____

APLICANT STATEMENT

I understand that any employment by Brookside Nursing Home, Inc. will be on a 520 working hour probationary basis. If employed by Brookside Nursing Home, Inc. I agree to abide by its rules and regulations. The above information is complete and true to the best of my knowledge. I understand that discovery of misrepresentation or omission of facts herein will be cause for immediate dismissal. I authorize Brookside Nursing home, Inc. or its authorized representative to contact any and/or all of my references for full information. I agree to take a physical examination at any time at the request of the facility at no personal expense to me, and I also agree that the examining physician may disclose the findings to Brookside Nursing Home, Inc. or its authorized representative. I understand that this application will be retained for one year from the date of application and will remain in the active file for ninety (90) days from date of application.

DATE _____ APPLICANT'S SIGNATURE _____

**Agency of Human Services
Department of Aging & Independent Living
Division of Licensing & Protection**

Adult Protective Services, 103 So. Main Street, Ladd Hall, Waterbury, VT 05671-2306

CONSENT FOR RELEASE OF INFORMATION

**HUMAN RESOURCES
BROOKSIDE NURSING HOME
120 CHRISTIAN STREET
WHITE RIVER JUNCTION, VT 05001**

~ THIS FORM WILL BE RETURNED IF ALTERED OR STAPLED ~

Section I. REQUEST FROM OWNER/OPERATOR

I hereby request the Commissioner of the Department of Aging & Independent Living to release to me any information in the Adult Abuse Registry pursuant to 33 V.S.A 6911 (C) (3) involving the individual listed below in Section II. I certify that this individual is a current employee, contractor or volunteer position of this facility/agency or has been given a conditional offer of employment. I understand this information is only for the purposes of offering employment, contract or volunteer position and agree it shall be otherwise kept confidential.

(Authorized) Facility/Agency Signature

Date

Section II. CONSENT FROM CURRENT OR PROSPECTIVE EMPLOYEE, CONTRACTOR OR VOLUNTEER

Name: _____ SS#: _____
(Type or Print)

Phone #: _____ Birth Date: _____ Place of Birth: _____

Other names I have used, if any: _____
(Type or Print)

I hereby authorize the Commissioner of Aging & Independent Living to release to the Owner/Operator of the above named facility/agency any information of reports of abuse, neglect or exploitation substantiated against me and contained in the Adult Abuse Registry pursuant to 33 V.S.A. 6911 (C) (3).

(Prospective) Staff, Contractor or Volunteer Signature

Date

(For APS Office Use Only)

Section III. RESPONSE FROM THE DEPARTMENT OF AGING & INDEPENDENT LIVING

The current information in the Adult Abuse Registry shows that there is not is

a substantiated finding of abuse, neglect or exploitation against the individual named above giving release of any such information. The nature of any finding is: _____

_____ and the date of such finding is: _____

Signature of Commissioner's Designee

Date: _____

Last Updated: 7/26/2004

REQUEST FOR CRIMINAL RECORD CHECK

1. Applicant: _____
Last First Middle
2. Maiden or Alias Names: _____

3. Social Security Number: _____ / _____ / _____
4. Place of Birth: _____ / _____ / _____
City/Town State Country
5. Date of Birth: _____ / _____ / _____
Month Day Year
6. Telephone Number: _____ / _____ - _____
Area Code Number

RELEASE

I, _____, hereby acknowledge and agree to check of any criminal record of convictions which may be maintained by the Vermont Criminal Information Center. I understand that the results of the check will be made available to Brookside Nursing Home of White River Jct. for use in reviewing my suitability for employment. I further understand that I have the right to appeal the results of the criminal record check to the Vermont Criminal Information Center, Department of Public Safety, 103 South Main Street, Waterbury, Vermont, 05671-2101.

Signature of Applicant: _____ Date: _____

Identity Verified by: _____ Date: _____