COMMUNITY HEALTH PROGRAMS, INC
Attn: Human Resources Department
444 Stockbridge Rd / P.O. Box 30
Great Barrington, MA 01230
HR@chpberkshires.org
Fax: (413) 528-2863

EMPLOYMENT APPLICATION

Applicant Information

Name

Last	*First*	*M.I.*

Address

Street Address	*Apartment/Unit #*

City	*Sate*	*ZIP Code*

Contact

Phone:	Email:

Are you authorized to work in the U.S.? YES ☐ NO ☐

Have you ever worked for this company? YES ☐ NO ☐ If yes, when?_____

Do you now, or will you in the future, require sponsorship for employment visa status to work legally in the U.S.? YES ☐ NO ☐

Position

Date Available:	Desired Salary: **$**

Please be specific

Position Applied for:	
Department/Practice:	
2nd Choice:	**3rd Choice:**

If you are applying for a clinical or dental position- please indicate a first, second and third choice of Practice.
Example: Department/Practice: Community Health Center | 2nd Choice: Lee Family Practice | 3rd Choice: Neighborhood Health Center

CHP Departments/Practices: Administration, Adams Internists, Barrington OB/GYN, Berkshire Pediatrics, Community Health Center, Family Services, Great Barrington Dental Center, Lee Family Practice, Mobile Health Unit, Neighborhood Dental Center, Neighborhood Health Center, North Adams Family Medical & Dental

How did you find out about this position?
☐ CHP Website ☐ LinkedIn ☐ Facebook ☐ Berkshirejobs ☐ Other Online Advertisement ☐ Employee Referral

☐ Recruiting Agency ☐ Paper Ad
Please Indicate Recruiting Agency, Referring Employee, or 'Other' Online or Paper Ad

Education

High School

Address

Street Address *City* *Sate* *ZIP Code*

From: To: ☐ **Diploma** ☐ **GED**

College

Address

Street Address *City* *Sate* *ZIP Code*

From: To: Degree:

Other (Graduate School, Technical School, etc.)

Address

Street Address *City* *Sate* *ZIP Code*

From: To: Degree:

Previous Employment

Employer **Supervisor**

Address

Street Address *City* *Sate* *ZIP Code*

Date Beginning: Date Ending:

Position/Title **Reason for Leaving**

Contact

Phone: Email:

May we contact your previous Supervisor for a reference? ☐ Yes ☐ No ☐ Later

Employer | **Supervisor**

Address

Street Address *City* *Sate* *ZIP Code*

Date Beginning: | Date Ending:

Position/Title | **Reason for Leaving**

Contact

Phone: | Email:

May we contact your previous Supervisor for a reference? ☐ Yes ☐ No ☐ Later

Employer | **Supervisor**

Address

Street Address *City* *Sate* *ZIP Code*

Date Beginning: | Date Ending:

Position/Title | **Reason for Leaving**

Contact

Phone: | Email:

May we contact your previous Supervisor for a reference? ☐ Yes ☐ No ☐ Later

Employer | **Supervisor**

Address

Street Address *City* *Sate* *ZIP Code*

Date Beginning: | Date Ending:

Position/Title	Reason for Leaving

Contact	
Phone:	Email:

May we contact your previous Supervisor for a reference? ☐ Yes ☐ No ☐ Later

Employer	Supervisor

Address

Street Address	*City*	*Sate*	*ZIP Code*

Date Beginning:	Date Ending:

Position/Title	Reason for Leaving

Contact	
Phone:	Email:

May we contact your previous Supervisor for a reference? ☐ Yes ☐ No ☐ Later

References

Please list three professional references- include at least one Manager/Supervisor.

Name	Yrs Known

Contact	
Phone:	Email:

Name	Yrs Known

Contact	
Phone:	Email:

Name	Yrs Known

Contact	
Phone:	Email:

Disclaimer and Signature

Community Health Programs is committed to providing equal employment opportunity (EEO) for all persons regardless of race, color, sex, sexual orientation, religion, marital status, parental status, physical or mental disability, age, veteran status, ancestry, or national or ethnic origin, genetics, retaliation, sexual harassment, political beliefs, or any other basis prohibited by applicable state, federal or local laws.

- The facts set forth in my application and attached resume are true and complete to the best of my knowledge. I understand that if employed, false statements or omissions on this application, my resume and all accompanying documents, are cause for termination, regardless of the time elapsed before discovery.

- I authorize Community Health Programs (CHP), to check and verify all information provided in my application, and hereby release CHP and its agents and employees from any claims, charges, or liabilities whatever that may result from the verification process. I understand that an offer of employment is contingent upon satisfactory proof of lawful employment status, as set forth in the Immigration Reform and Control Act of 1986 and reference and background checks. Permission is hereby given to CHP or any agent thereof to investigate previous employment, educational background and reference information including job performance, employment dates, etc.

- I release CHP its subsidiaries and former employers from any liability resulting from any information provided in connection with this application.

Please note: CHP requires all employees to agree to and obtain a clear Criminal Offender Record Information (CORI) check as a condition of employment and as a Federally Qualified Health Care Center must not hire anyone on the US Department of Health and Human Services Office of Inspector General Exclusions List: http://oig.hhs.gov/fraud/exclusions.asp

CHP is a drug-free, alcohol-free, smoke-free work environment. Prospective employees must agree to meet all pre-employment health requirements. Employees may be asked for additional tests/information depending on the job requirement. I understand that the receipt of this application does not imply that I will be employed. All employees of CHP are employees-at-will. This means CHP has the right to discontinue an employee's employment at any time at its discretion, with or without cause (but not for an illegal or discriminatory reason) and that you may leave at any time at your discretion. I understand that this employment application is not an expressed or implied employment contract.

Signature: _____ Date: _____

Voluntary Self-Identification of Gender and Race/Ethnicity

Our company is an equal opportunity employer and does not discriminate in hiring or employment on the basis of race, color, sex, national origin, age, disability or any other basis prohibited by federal, state or local law. No question on this form is intended to secure information to be used for such discrimination.

Community Health Programs, Inc. is subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, we invite our applicants to voluntarily self-identify their race/ethnicity, gender, disability and veteran status.

Submission of this information is voluntary, and refusal to provide it will not subject you to any adverse treatment. The information will be kept confidential and may only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement.

Invitation to Self-Identify

☐ I understand the reason for this request for voluntary self-identification as stated above and **choose to decline.**

☐ I understand the reason for this request for voluntary self-identification as stated above and **have opted to complete this form.**

What is your gender?

☐ Male
☐ Female

Which race/ethnicity do you identify with? You may mark only one box:

☐ **Hispanic or Latino:** a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

☐ **White (Not Hispanic or Latino):** a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ **Black or African American (Not Hispanic or Latino):** a person having origins in any of the black racial groups of Africa.

☐ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)**: a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **Asian (Not Hispanic or Latino)**: a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **American Indian or Alaska Native (Not Hispanic or Latino)**: a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

☐ **Two or more races (Not Hispanic or Latino)**: a person who primarily identifies with two or more of the above races.

Signature:_____Date:_____

Voluntary Self-Identification of Veteran Status

Community Health Programs, Inc. requests applicants to self-identify as veterans or disabled veterans for affirmative action purposes. This information is requested solely for use in connection with its affirmative action obligations and/or its affirmative action efforts. This information is being requested on a voluntary basis, will be kept confidential in accordance with the Americans With Disabilities Act (ADA), and will be used solely in accordance with the ADA.

Submission of this information is voluntary, and refusal to provide it will not subject you to any adverse treatment.

Community Health Programs, Inc. is subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA), which requires the City to take affirmative action to employ and advance in employment **protected veterans**. This includes (1) disabled veterans; (2) recently separated veterans; (3)active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans (defined below). As a Government contractor subject to VEVRAA, we request this information in order to measure the effectiveness of the outreach and positive recruitment efforts we undertake pursuant to VEVRAA.

If you believe you belong to any of the categories of protected veterans listed above, please indicate by checking the appropriate box below.

Veteran Status: please check one of the boxes below:

☐ I identify as one or more of the classifications of protected veteran defined below (disabled veteran; recently separated veteran; active duty wartime or campaign badge veteran; or armed forces service medal veteran).

☐ I am NOT a protected veteran/do not identify with any of the protected veteran classifications listed below.

☐ I do not wish to self-identify

Definitions:

A "**disabled veteran**" is one of the following:
- a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or
- a person who was discharged or released from active duty because of a service-connected disability.

A "**recently separated veteran**" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.

An "**active duty wartime or campaign badge veteran**" means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.

An "**Armed forces service medal veteran**" means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

Protected veterans may have additional rights under USERRA—the Uniformed Services Employment and Reemployment Rights Act. In particular, if you were absent from employment in order to perform service in the uniformed service, you may be entitled to be reemployed by your employer in the position you would have obtained with reasonable certainty if not for the absence due to service. For more information, call the U.S. Department of Labor's Veterans Employment and Training Service (VETS), toll-free, at 1-866-4-USA-DOL.

Signature:_____Date:_____

Voluntary Self-Identification of Disability

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.[1] To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

Please check one of the boxes below:

☐ Yes, I have a disability

☐ No, I don't have a disability

☐ I don't wish to answer

Signature:_____Date:_____

Reasonable Accommodation Notice

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

[1] Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

Form CC-305 OMB
Control Number 1250-0005
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