

# NobleHospital

[www.NobleHospital.org](http://www.NobleHospital.org)

*Your community hospital of choice.*

## APPLICATION FOR EMPLOYMENT

Noble Hospital is an **Equal Opportunity Employer** and considers applicants for all positions without regard to race, color, religion, sex, national origin, age, veteran status, handicap, ancestry, sexual orientation, or an applicant's marriage to, or association with, an individual of a particular race, religion, national origin, or an individual with a disability.



## Education

	Name and Address of School	Degree Obtained	Course or Major	Completed		Year Completed
				Yes	No	
High School						
College						
Nursing						
Other						

List any Honors Received \_\_\_\_\_

## Employment History

(Please list most recent experience first. Include military service assignments and work performed on a volunteer basis.)

Employer Name	Telephone Number ( )	Salary
Address	Employment Dates From	To
Job Title	Supervisor's Name	
Duties		
Reason for Leaving		

Employer Name	Telephone Number ( )	Salary
Address	Employment Dates From	To
Job Title	Supervisor's Name	
Duties		
Reason for Leaving		

Employer Name	Telephone Number ( )	Salary
Address	Employment Dates From	To
Job Title	Supervisor's Name	
Duties		
Reason for Leaving		

May we contact your present employer(s)     Yes     No

## Professional References

Name	Telephone Number ( )
Address	Occupation

Name	Telephone Number ( )
Address	Occupation

Name	Telephone Number ( )
Address	Occupation

## Emergency Contact

Name	Telephone Number (    )
Address	

**Referral Source:**     Advertisement     Employment Agency     Walk-in  
 Employee/Friend/Relative \_\_\_\_\_     Other \_\_\_\_\_

## Read Before Signing

I certify that answers given herein are true and complete to the best of my knowledge.

I authorize investigation of all statements contained in this application, and understand that any misstatement of fact shall be cause for dismissal. I understand my employment is conditional until I successfully pass a reference check.

Upon being offered employment, I agree to submit to a medical examination to determine my physical capability of performing the essential functions of the offered position with or without reasonable accommodation. I also understand that my employment is contingent upon passing the medical examination.

As a condition of my employment, I understand that hospital policy requires all employees to share day, evening, night and weekend duty in accordance with the hospital's needs, and that reassignment of employees will also be in accordance with the needs of the hospital.

I understand that this application is not and is not intended to be an established contract between Noble Hospital and myself.

If I am employed in a position not covered by a Collective Bargaining Agreement, I will be employed at-will and understand that my employment and compensation may be terminated, with or without cause, and with or without notice, at any time at my option or the Hospital's.

I acknowledge that, in addition to the application, no other written or oral communication from employer representatives is intended to create an employment contract binding on any party.

I acknowledge that if employed, I will be required to show proof of citizenship or other evidence to show that I have an unrestricted right to work in the United States.

It is unlawful in Massachusetts to require or administer a lie detector test as a condition of employment or continued employment. An employer who violates this law shall be subject to criminal penalties and civil liability.

I understand that I am required to abide by all rules and regulations of the hospital.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

<b>PLEASE DO NOT WRITE BELOW THIS LINE</b>					
Department	Department #	Position	Date of Hire	Hourly Rate	Step
<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Temporary	<input type="checkbox"/> Per-Diem	<input type="checkbox"/> Rehire	Hours Per
<input type="checkbox"/> Exempt	<input type="checkbox"/> Non-Exempt	<input type="checkbox"/> New Position	<input type="checkbox"/> Replacement for		

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115 West Silver Street, Westfield, MA 01085 (413) 568-2811  
www.NobleHospital.org

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## CORI REQUEST FORM

Noble Hospital has been certified by the Criminal History Systems Board for access to conviction and pending criminal case data. As an applicant/employee of Noble Hospital, I understand that a criminal record check will be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. The information below is correct to the best of my knowledge.

APPLICANT/EMPLOYEE SIGNATURE \_\_\_\_\_

Applicant/Employee information (Please Print Clearly)

\_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE NAME

\_\_\_\_\_  
MAIDEN NAME OR ALIAS (IF APPLICABLE) PLACE OF BIRTH

\_\_\_\_\_  
DATE OF BIRTH SOCIAL SECURITY NUMBER ID Theft Index PIN  
(Requested but not required) (if applicable)\*

\_\_\_\_\_  
MOTHER'S MAIDEN NAME

CURRENT AND FORMER ADDRESSES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SEX: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ft. \_\_\_\_\_in. WEIGHT: \_\_\_\_\_ EYE COLOR: \_\_\_\_\_

STATE DRIVER'S LICENSE NUMBER: \_\_\_\_\_

Include state of issue.

Include a copy of your driver's license or Government issued identification

Below this line to be completed by CORI authorized employee

\*\*\*THE ABOVE INFORMATION WAS VARIFIED BY REVIEWING THE FOLLOWING FORM OF  
GOVERNMENT ISSUED PHOTOGRAPHIC IDENTIFICATION: \_\_\_\_\_

REQUESTED BY: \_\_\_\_\_  
SIGNATURE OF CORI AUTHORIZED EMPLOYEE

\* The CHSB Identify Theft Index Pin Number is to be completed by those applicants that have been issued an Identity Theft Index PIN Number by the CHSB. Certified agencies are required to provide all applicants the opportunity to include this information to ensure the accuracy of the CORI request process. **All CORI request forms that include this field are required to be submitted to the CHSB via mail or by fax to 617-660-4614.**





I certify that all answers provided on all above documentation is correct to the best of my knowledge.  
My typed name below shall have the same force and effect as my written signature

Applicants Signature \_\_\_\_\_ Date \_\_\_\_\_

Please click on *Save Form* below to save a copy to your computer. Please email this file  
to: [hres@noblehealth.org](mailto:hres@noblehealth.org)

Thank you.