

OPPORTUNITY NETWORKS - EMPLOYMENT APPLICATION

Name: _____ Date: _____
Present address _____ Zip _____
Telephone _____ SS# _____
Position Applying for _____ Minimum Acceptable Salary _____
Are you presently employed? _____
Company _____
Position _____
Date of Hire _____
May we contact you present employer? _____
Address _____ Telephone _____
Reason for leaving _____

EDUCATIONAL AND PROFESSIONAL TRAINING

NAME/LOCATION	MAJOR/MINOR COURSE	DEGREE CERTIFICATION	YEAR GRADUATION	DATE ATTENDED
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PROFESSIONAL EXPERIENCE

NAME/ADDRESS	POSITION HELD	DATES	NAME OF SUPERVISOR
_____	_____	_____	_____
_____	_____	_____	_____

OTHER EXPERIENCE

(FULL AND PART-TIME, SUMMERS, MILITARY, ETC.)

Have you had any teaching and/or personal experience with developmentally disabled people?

YES _____ NO _____

If yes, please explain _____

What interests you in working with developmentally disabled people? _____

List 3 professional references with phone numbers. (May we contact them? Y__N__)

Have you within the past 3 years, ever had you license suspended or revoked? YES _____ NO _____

If yes, please explain _____

Is your vehicle currently insured? YES _____ NO _____

Have you ever had a complaint filed against you that was founded for abuse, neglect or exploitation at ANY Agency or Region? YES _____ NO _____

Have you ever been convicted of a misdemeanor, felony or other criminal act?

YES _____ NO _____.

If yes, please explain _____

I give Networks permission to investigate the validity of the information provided and agree to provide additional information if necessary. I understand that all information provided will be kept strictly confidential. I further understand that any false information may result in my immediate dismissal from networks employment.

APPLICANT'S SIGNATURE

DATE

APPLICANT'S DRIVERS LICENSE NUMBER

OFFICIAL USE ONLY

APPLICATION REVIEWED BY _____

DATE: _____

Hired Y__N__ Position _____

Date _____ Rate of Pay _____

State of New Hampshire
Department of Health and Human Services
Bureau of Elderly and Adult Services (BEAS)

BEAS STATE REGISTRY CONSENT FORM
(RSA 161-F: 49*)

Employer Information

I hereby authorize the release of any adult abuse, neglect, and/or exploitation record that you might find concerning me to: *(This portion must be filled out in order to be processed.)*

Employer name: _____
Mailing address: _____
City/State/Zip: _____
Telephone: _____
Fax: _____

For Official Use Only

Employee Information

PLEASE PRINT IN CLEAR BLOCK LETTERS

(If content is illegible, it will be stamped "Unable to Process" and returned.)

Last name: _____ First name: _____ Middle Initial: ____
Mailing address: _____ City/State/Zip: _____
Telephone _____ Gender: Female Male

Also known by the following names (Maiden name, etc.):

Last name: _____ First name: _____ Middle Initial: ____
Last name: _____ First name: _____ Middle Initial: ____

Date of Birth: Month: _____ Day: _____ Year: _____ Social Security #: _____
(Required) (Optional)

Position: _____ Select one: Applying Current Position
 Employee Consultant Volunteer Other: _____

I understand that the information disclosed and provided by BEAS, under this State Registry Consent Form, is intended for use by the above-named employer in conjunction with my employment/volunteering.

Employee Signature: _____ Date: _____
Witness Signature: _____ Date: _____
(Required)

Fax to: (603) 271-6875 or **Email:** BEASStateRegistry@dhhs.nh.gov
or **Mail** to: BEAS State Registry, 129 Pleasant Street, Concord, NH 03301

***This record check pertains only to findings made on or after July 1, 2007 pursuant to RSA 161-F: 49.**