EMPLOYMENT APPLICATION

ChristCare Wellness Center PLLC

General Employment Application

POSITION APPLYING FOR

☐ Registered Nurse (RN)
☐ Licensed Practical Nurse (LPN)
☐ Medical Assistant (MA)
☐ Front Desk / Patient Services
☐ Other: _____

APPLICATION INFORMATION

Application Date _____ Desired Start Date _____

Employment Type:

☐ Full-Time ☐ Part-Time ☐ Per Diem

Desired Salary (optional) _____

PERSONAL INFORMATION

Full Name _____ Preferred Name _____

Address _____

City _____ State _____ ZIP _____

Cell Phone _____ Email _____

Preferred Method of Contact:

☐ Phone ☐ Email

ELIGIBILITY

Are you legally authorized to work in the United States?

☐ Yes ☐ No

Will you now or in the future require employment sponsorship?

☐ Yes ☐ No

Have you ever worked for ChristCare Wellness Center PLLC?

☐ Yes ☐ No

If yes, when? _____

AVAILABILITY

Days Available:

☐ Monday ☐ Tuesday ☐ Wednesday

☐ Thursday ☐ Friday ☐ Saturday

Preferred Hours

Available to work evenings?

☐ Yes ☐ No

Available for occasional weekends?

☐ Yes ☐ No

EDUCATION

Highest Degree | School

City/State | Graduation Date

PROFESSIONAL LICENSES / CERTIFICATIONS

License Type | State

License Number | Expiration Date

Board Certified?

☐ Yes ☐ No

CERTIFICATIONS

☐ BLS ☐ ACLS ☐ PALS ☐ CPR

☐ CMA ☐ RMA ☐ OSHA ☐ HIPAA

Other

EMPLOYMENT HISTORY

Most Recent Employer

Employer | Position

Dates Employed | Supervisor | Phone

Reason for Leaving

Responsibilities

Previous Employer

Employer | Position

Dates Employed | Supervisor | Phone

Reason for Leaving

SIGNATURE

I certify that the information provided is true and complete to the best of my knowledge.

Applicant Signature

Date

ChristCare
WELLNESS CENTER PLLC
— Compassionate Care. Whole-Person Wellness. —

42 Lancaster Street, Unit 2
Leominster, MA 01453
(978) 775-2067
careers@christcarewellnesscenter.com
www.christcarewellnesscenter.com

NURSE PRACTITIONER
SUPPLEMENTAL APPLICATION

POSITION APPLYING FOR

- ☐ Family Nurse Practitioner (FNP)
- ☐ Psychiatric Mental Health Nurse Practitioner (PMHNP)
- ☐ Dual Certified

Application Date: _____

Applicant Name: _____

PROFESSIONAL LICENSURE

Massachusetts APRN License Number _____ Expiration Date: _____

Massachusetts RN License Number _____ Expiration Date: _____

National Provider Identifier (NPI) _____

Massachusetts Controlled Substance Registration (MCSR) _____

DEA Registration Number _____ Expiration Date: _____

Board Certification: ☐ ANCC ☐ AANP ☐ PMHNP-BC ☐ Other _____

Expiration Date: _____

MALPRACTICE INSURANCE

Current Carrier: _____

Policy Number: _____

Coverage Limits: _____

Expiration Date: _____

Have you ever had malpractice claims?

☐ No ☐ Yes (Please explain)

_____

_____

EDUCATION

Graduate Nursing School: _____

Degree Earned:

☐ MSN ☐ DNP ☐ PhD ☐ Other: _____

Graduation Date: _____

Clinical Hours Completed: _____

PROFESSIONAL EXPERIENCE

Years as a Nurse Practitioner: _____

Years as a Registered Nurse: _____

Primary Specialty (Check all that apply):

☐ Family Practice ☐ Internal Medicine ☐ Adult Medicine
☐ Behavioral Health ☐ Psychiatry ☐ Geriatrics
☐ Urgent Care ☐ Other: _____

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CLINICAL EXPERIENCE

Please indicate your level of experience.

Clinical Service	None	Limited	Proficient	Expert
Preventive Care	☐	☐	☐	☐
Annual Wellness Visits	☐	☐	☐	☐
Hypertension Management	☐	☐	☐	☐
Diabetes Management	☐	☐	☐	☐
Thyroid Disorders	☐	☐	☐	☐
Women's Health	☐	☐	☐	☐
Obesity Medicine	☐	☐	☐	☐
Weight Management	☐	☐	☐	☐
Metabolic Syndrome	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Anxiety Disorders	☐	☐	☐	☐
ADHD	☐	☐	☐	☐
Substance Use Disorders	☐	☐	☐	☐
Geriatric Care	☐	☐	☐	☐
Telehealth	☐	☐	☐	☐

PROCEDURAL EXPERIENCE

Please check all that apply.

- ☐ Joint Injections
- ☐ Trigger Point Injections
- ☐ Skin Biopsies
- ☐ Suturing
- ☐ Incision & Drainage
- ☐ Cryotherapy
- ☐ Women's Health Procedures
- ☐ Pap Smears
- ☐ EKG Interpretation
- ☐ Point-of-Care Ultrasound
- ☐ IUD Insertion/Removal
- ☐ Nexplanon Insertion/Removal
- ☐ Colposcopy
- ☐ None
- ☐ Other: _____

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ELECTRONIC HEALTH RECORDS

Please indicate systems you have used. (Check all that apply)

☐ Practice Fusion ☐ Epic ☐ eClinicalWorks ☐ Athenahealth
☐ Cerner ☐ NextGen ☐ Allscripts ☐ Meditech
☐ Other: _____

Years of EHR Experience: _____

QUALITY IMPROVEMENT

Have you participated in the following? (Check Yes or No)

	Yes	No
Quality Improvement Projects	☐	☐
Clinical Leadership	☐	☐
Population Health Initiatives	☐	☐
Value-Based Care Programs	☐	☐

If yes, please describe your role and the outcomes.

_____
_____
_____
_____

PATIENT CARE PHILOSOPHY

Describe your approach to patient-centered, whole-person care.

_____
_____
_____

CONTINUING EDUCATION

Please list relevant continuing education (past 3 years).

Course / Conference / Topic	Provider	Date Completed	CME Hours

PROFESSIONAL AFFILIATIONS

Please list professional organizations of which you are a member.

_____
_____
_____
_____

ADDITIONAL INFORMATION

Is there any additional information that you feel would be beneficial to our review of your application?

_____
_____
_____
_____

PROFESSIONAL REFERENCES

Please provide at least three professional references who can speak to your clinical competence and professional character.

REFERENCE 1

Name: _____
Title: _____
Organization: _____
Relationship: _____
Phone: _____
Email: _____

REFERENCE 2

Name: _____
Title: _____
Organization: _____
Relationship: _____
Phone: _____
Email: _____

REFERENCE 3

Name: _____
Title: _____
Organization: _____
Relationship: _____
Phone: _____
Email: _____

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EMPLOYMENT HISTORY – NURSE PRACTITIONER ROLE

Please list your most recent Nurse Practitioner positions (begin with most recent). Add additional pages if needed.

Employer / Organization	Position / Title	Dates Employed (From – To)	Average Weekly Hours	Reason for Leaving

ADDITIONAL INFORMATION

Is there any additional information (criminal history, gaps in employment, disciplinary actions, etc.) that we should be aware of?

☐ No ☐ Yes (If yes, please explain below.)

_____

_____

_____

_____

_____

DOCUMENT CHECKLIST

Application will not be considered complete without the following:

- ☐ Resume / CV
- ☐ Copy of APRN License (MA)
- ☐ Copy of RN License (MA)
- ☐ Copy of National Certification
- ☐ DEA Registration (if applicable)
- ☐ MCSR Registration (if applicable)
- ☐ NPI Confirmation
- ☐ Malpractice Insurance Declaration Page
- ☐ Transcripts (Unofficial acceptable at this time)

CERTIFICATION AND AUTHORIZATION

I certify that all information provided in this application is true and complete to the best of my knowledge.

I understand that any omission or false statement may result in disqualification from employment consideration or termination of employment if hired.

I authorize ChristCare Wellness Center PLLC to verify all information contained in this application, including education, licensure, employment history, certifications, and professional references, as permitted by law.

SIGN

_____ _____

Applicant Signature Date

FOR OFFICE USE ONLY

Date Received: _____

Received By: _____

Application Status: ☐ New ☐ In Review ☐ Interview ☐ Hired ☐ Not Hired

Interview Date: _____

Hiring Manager: _____

Notes: _____

_____