



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

DEPARTMENT OF ADMINISTRATION
 DIVISION OF HUMAN RESOURCES
 OFFICE OF PERSONNEL ADMINISTRATION
 One Capitol Hill
 Providence, Rhode Island 02908-5860

**FOR HUMAN RESOURCES USE
 ONLY**
 APPLICATION # _____

TELEPHONE: 222-2172
 RI RELAY 711
 AN EQUAL OPPORTUNITY EMPLOYER

IMPORTANT: RESIDENCY REQUIREMENT (REF GL 36-4-18)

INSTRUCTIONS: Only that information specifically listed on this application will be considered in determining your qualifications for the examinations for which you have applied. Insufficient information may result in rejection from an examination or a lower score on your Education and Experience rating.

The Office of Personnel Administration reserves the right to investigate all statements made on your application, and to require proof of such statements when deemed necessary. Any individual with a disability who requires assistance during the exam process should notify the Examination Section 7 Days in advance to ensure that appropriate accommodations will be made.

Retain a copy of this application for your records, as it will not be returned to you. Attach additional pages if needed.

PLEASE PRINT OR TYPE ALL INFORMATION LEGIBLY

SOCIAL SECURITY NUMBER _____

NOTE: Providing your Social Security Number is voluntary in accordance with the Privacy Act of 1974. Your cooperation is encouraged, as this information is necessary for properly crediting you with veteran's credit or bonus points for determining eligibility for promotional examinations in accordance with State Law.

NAME _____
FIRST MI LAST

RESIDENCE _____
MAILING ADDRESS

_____ CITY STATE ZIP CODE

TELEPHONE _____
HOME CELL

DO NOT WRITE IN THIS BLOCK FOR OFFICIAL USE ONLY

VPTS: _____ Init: _____

Prom: _____ Stat: _____

Lang: _____

Class: _____

Base: _____

Init: _____

Date: _____

Serial: _____

COMPLETE THIS SECTION ONLY IF YOU CLAIM TO BE A WAR VETERAN.

WAR TIME SERVICE DATES APPLICABLE UNDER RHODE ISLAND LAW (Ref GL 36-4-19):

12/7/41 - 12/31/46	8/20/82 - 12/31/87
6/27/50 - 1/31/55	12/20/89 - 1/31/90
7/1/58 - 1/1/59	8/2/90 - 7/13/92
8/5/64 - 5/7/75	

If disabled veteran, V.A. Claim Number: _____

If you claim veteran's credit, attach a copy of your separation papers (usually Form DD-214) to this application. If you are also a Disabled Veteran, attach a copy of V.A. Form FL 21-802 (Disabled Veteran's Preference Form). THE PAPERS WILL NOT BE RETURNED TO YOU. **Only with the required papers will you receive veteran's service credit.**

List the **TITLE AND NUMBER** of *each* exam for which you are applying.

1. _____
2. _____
3. _____
4. _____
5. _____

CHECK THOSE LANGUAGES IN WHICH YOU ARE FLUENT:

<input type="checkbox"/> ENGLISH	<input type="checkbox"/> PORTUGUESE	<input type="checkbox"/> SPANISH	<input type="checkbox"/> THAI	<input type="checkbox"/> VIETNAMESE
<input type="checkbox"/> FRENCH	<input type="checkbox"/> HMONG	<input type="checkbox"/> CAMBODIAN	<input type="checkbox"/> ITALIAN	<input type="checkbox"/> LAO
<input type="checkbox"/> SIGN LANGUAGE	<input type="checkbox"/> OTHER (specify) _____			

NOTE: YOU are responsible for applications sent through the mail.

COMPLETION OF THE SIGNATURE BLOCK IS REQUIRED. UNSIGNED APPLICATIONS WILL BE RETURNED UNPROCESSED.

I certify to the truth and completeness of all statements made on this application. I have read and understand the instructions as specified on this application, and recognize that any false or deceptive statement or omission of material fact may bar me from examination(s) or may result in my removal from appropriate civil service lists or my dismissal from State Service.

 Signature

 Date

B. EMPLOYER NAME & ADDRESS: _____ _____	DATES EMPLOYED: FROM: _____ TO: _____
SUPERVISOR'S TITLE: _____	TOTAL TIME IN POSITION _____ YEARS _____ MONTHS # of hours per week _____ ANNUAL SALARY: \$ _____
YOUR POSITION TITLE: _____	
DUTIES _____ _____ _____ _____ _____ _____ _____	

NUMBER AND TYPES OF EMPLOYEES SUPERVISED: _____ _____ FOR HOW LONG? _____	



C. EMPLOYER NAME & ADDRESS: _____ _____	DATES EMPLOYED: FROM: _____ TO: _____
SUPERVISOR'S TITLE: _____	TOTAL TIME IN POSITION _____ YEARS _____ MONTHS # of hours per week _____ ANNUAL SALARY: \$ _____
YOUR POSITION TITLE: _____	
DUTIES _____ _____ _____ _____ _____ _____ _____	

NUMBER AND TYPES OF EMPLOYEES SUPERVISED: _____ _____ FOR HOW LONG? _____	

D. EMPLOYER NAME & ADDRESS: _____ _____	DATES EMPLOYED: FROM: _____ TO: _____	
SUPERVISOR'S TITLE: _____	TOTAL TIME IN POSITION _____ YEARS _____ MONTHS # of hours per week _____ ANNUAL SALARY: \$ _____	
YOUR POSITION TITLE: _____		
DUTIES _____ _____ _____ _____ _____ _____ _____ _____		
NUMBER AND TYPES OF EMPLOYEES SUPERVISED: _____ _____ FOR HOW LONG? _____		



E. EMPLOYER NAME & ADDRESS: _____ _____	DATES EMPLOYED: FROM: _____ TO: _____	
SUPERVISOR'S TITLE: _____	TOTAL TIME IN POSITION _____ YEARS _____ MONTHS # of hours per week _____ ANNUAL SALARY: \$ _____	
YOUR POSITION TITLE: _____		
DUTIES _____ _____ _____ _____ _____ _____ _____		
NUMBER AND TYPES OF EMPLOYEES SUPERVISED: _____ _____ FOR HOW LONG? _____		