St. Johnsville Rehabilitation & Nursing Center, Inc.

7 Timmerman Avenue
St. Johnsville NY 13452
Phone: 518-568-5037, ext. 4261
Fax: 888-241-4392
www.stjrnc.com

Dear Applicant:

Thank you for expressing interest in employment with the St. Johnsville Rehabilitation & Nursing Center, Inc. Your qualifications and skills will be reviewed, and if they meet our requirements, you will be contacted to arrange an interview.

Once again, thank you for your interest in St. Johnsville Rehabilitation & Nursing Center, Inc.

Sincerely,

Hope Achzet
Director of Human Resources

St. Johnsville Rehabilitation & Nursing Center, Inc.
7 Timmerman Avenue **Telephone: 518-568-5037**
St. Johnsville NY 13452 **Fax: 888-241-4392**

APPLICANT INFORMATION			
Last Name:	First	M.I.:	Date:
Street Address:		Apartment/Unit #:	
City:	State:	Zip:	
Phone:	Alternate Contact:		
Social Security #:	Email:		
Are you legally authorized to work in the United States? YES ☐ NO ☐ *Proof of legal authorization will be required upon hire.*			
Are you over 18 years of age? YES ☐ NO ☐	If no, can you produce a work permit upon hire? YES ☐ NO ☐		
Have you ever worked for this company? YES ☐ NO ☐	If so, provide **last name** and **dates** of employment. Last Name: Dates:		
Have you ever been convicted of a crime: YES ☐ NO ☐	Have you ever been excluded from participation in any Federal or State program that includes, but is not limited to Medicare, Medicaid or any other governmental agency? YES ☐ NO ☐		
Applicant Referred: NEWSPAPER ☐ CURRENT EMPLOYEE ☐_____ Other ☐ _____			
Position Desired:	Desired Salary:	Date Available:	

EDUCATION			
High School:			Name of Institution:
Did you graduate?	YES ☐	NO ☐	Street Address:
Degree:			City, State, Zip:
College:			Name of Institution:
Did you graduate	YES ☐	NO ☐	Street Address:
Degree:			City, State, Zip
Trade School/Certification Program:			Name of Institution
Did you graduate?	YES ☐	NO ☐	Street Address:
Degree:			City, State, Zip
Professional License Type: RN LPN Other _____ Professional License Number: _____ Nurse Aide Certificate No.: _____ Effective Date: Valid Thru:			**NOTE:** *Limited applicants are responsible for permit application/fees. Please inquire with the Human Resource Director for questions regarding limited permits.*

PERSONAL REFERENCES ***MUST BE COMPLETED TO BE CONSIDERED FOR EMPLOYMENT***	
Full Name:	Phone: ( )
Street Address:	City, State, Zip
Full Name:	Phone: ( )
Street Address:	City, State, Zip
Full Name:	Phone: ( )
Street Address:	City, State, Zip

EMPLOYMENT STATUS			
Are you currently employed? YES □ NO □		If yes, may we contact your present employer? YES □ NO □	
Company		Phone: ( )	
Street Address:			
Job Title:		Supervisor:	
		Start Date:	End Date:
PREVIOUS EMPLOYMENT			
Company:		Phone: ( )	
Street Address:			
Job Title:		Supervisor:	
		Start Date:	End Date:
Reason for Leaving:			
May we contact your previous supervisor for a reference? YES □ NO □			
Company:		Phone: ( )	
Street Address:			
Job Title:		Supervisor:	
		Start Date:	End Date:
Reason for Leaving:			
May we contact your previous supervisor for a reference? YES □ NO □			
Company:		Phone: ( )	
Street Address:			
Job Title:		Supervisor:	
		Start Date:	End Date:
Reason for Leaving			
May we contact your previous supervisor for a reference? YES □ NO □			

EQUAL OPPORTUNITY EMPLOYER

The St. Johnsville Rehabilitation & Nursing Center, Inc. is an equal opportunity employer. Discrimination is prohibited on sex, creed, color, national origin, religion, marital status, veteran status, sexual orientation, gender identity or expression, military status, disability, predisposing genetic characteristics, familial status, or domestic violence status.

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.
I hereby authorize investigation of all statements contained in this application. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.
I understand that misrepresentation or omission of the facts called for is cause for dismissal. Furthermore, I understand and agree that my employment is for no definite period and may, regardless of the date of payment of my wages, be terminated at any time without previous notice.
I understand that background checks and fingerprinting will be completed on all non-licensed personnel. All employment will be considered temporary until receipt of the criminal background check and employment approval provided by the NYS Department of Health. I consent to drug testing, physical capability testing specific to the position(s) applied, any physical health screening provided by or contracted by St. Johnsville Rehabilitation & Nursing Center, Inc.

Signature: _____ Date: _____

NOTICE TO APPLICANT: SIGNED AUTHORIZATION BELOW IS REQUIRED IN ORDER FOR THE ST. JOHNSVILLE REHABILITATION AND NURSING CENTER, INC. TO OBTAIN/VERIFY ALL NECESSARY INFORMATION FOR EMPLOYMENT CONSIDERATION.

*****APPLICANT: COMPLETE FRONT PORTION OF THIS FORM ONLY*****

Reference Authorization

I hereby voluntary consent to allow the **St. Johnsville Rehabilitation & Nursing Center, Inc.,** any of its officers or authorized employees to check my appropriate references by asking any questions which they consider relevant to their hiring decision, including questions about my educational background, work experience, character and ability to interact with people.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

DEPARTMENT: _____ **ATTENTION: _____**

DATE SENT: _____ **DATE RECEIVED: _____**

PLEASE SEE REVERSE FOR APPLICANTS SIGNED AUTHORIZATION

St. Johnsville Rehabilitation & Nursing Center, Inc.
CHRC Data Entry Form

Please Print, One Letter per Box

First Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle Initial: ☐

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date of Birth (mm/dd/yyyy): ☐☐ ☐☐ ☐☐☐☐

Last Four Digits of Social Security Number: ☐☐☐☐

Maiden Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Alias (AKA): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Street Number: ☐☐☐☐☐ or P.O. Box Number: ☐☐☐☐☐

Street Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

State: ☐☐

Zip Code: ☐☐☐☐☐

Apartment Number: ☐☐☐☐☐☐

Home Phone (xxx-xxx-xxxx): ☐☐☐-☐☐☐-☐☐☐☐

Cell Phone (xxx-xxx-xxxx): ☐☐☐-☐☐☐-☐☐☐☐

Birth Country: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

KEY

Sex Field:	**Race Field:**	**Hair Field:**	**Eye Field:**
M: Male F: Female	A: Asian Decedent B: African black racial groups I: American Indian, Eskimo, Alaskan Native U: Of Indeterminable Race W. Caucasian or Spanish Origin	Bal: Bald Blk: Black Bln: Blonde/Strawberry Blu: Blue Bro: Brown Grn: Green Gry: Gray or Partial Ong: Orange Pnk: Pink Ple: Purple Red: Red or Auburn Sdy: Sandy Whi: White Xxx: Unknown	Blk: Black Blu: Blue Bro: Brown Grn: Green Gry: Gray Haz: Hazel Mar: Maroon Mul: Multicolored Pnk: Pink Xxx: Unknown

Gender: ☐ Race: ☐ Height (ft): ☐ Height (in): ☐

Weight: ☐☐☐ Eyes: ☐☐☐ Hair: ☐☐☐

EEO QUESTIONNAIRE

(Refusal to complete this form will have **no** effect whatsoever on consideration of you for employment.
See instruction on other side – VOLUNTARY Request for Information)

(PLEASE PRINT)

DATE: _____ Gender: ☐ Male ☐ Female AGE: _____

NAME: _____
LAST **FIRST** **MI**

Position(s) Applied for: _____

How did you learn about the position(s) (i.e.: website, newspaper ad, current employees, etc.):

_____

RACE/ETHNIC DATA:

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

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

☐ D. **American or Black** (**Not Hispanic or Latino) -** A person having origins in any black racial groups of Africa.

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

☐ F. **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.

☐ G. **Native 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 maintain tribal affiliation or community attachment.

☐ H. **Two or More Races** (**Not Hispanic or Latino) –** All persons who identify with more than one of the above six races.

☐ **I do not wish to enter voluntary self-identification EEOC information.**

Do you consider yourself a person with a disability? ☐ Yes ☐ No

Person with a disability: Any person who has a physical or mental impairment that substantially limits one or more major life activities and that affects employability, has a record of having such impairment or is regarded as having such impairment.

I understand that this information will be kept confidential and used only in accordance with applicable Federal laws and regulations.

Signature: _____ Date: _____

AN EQUAL OPPORTUNITY EMPLOYER

EQUAL EMPLOYMENT OPPORTUNITY
QUESTIONNAIRE

This form is **NOT** part of the Employment Application. This information will **NEVER** be kept with the completed Employment Application form, and it will **NEVER** be used as a basis for offering or not offering an applicant a job.

The answers to the questions located on the back of this form are for the EEO Compliance purposes only.

As employers/government contractors, we comply with the Federal government regulations which require that employers take affirmative action to provide equal employment opportunity and maintain records to substantiate their efforts. To ensure compliance, we are periodically required to report on the race, age, sex, and disability status of applicants. This data is for analysis and affirmative action purposes only.

To assist us in complying with government record keeping and other legal documents, please fill out the EEO Questionnaire. Do not hesitate to ask questions or seek assistance. Providing this information is strictly on a voluntary basis, and refusal to provide it will not subject you to any adverse treatment. Any information provided by you will be kept confidential and will be used only in accordance with applicable Federal laws and regulations.

DOH CHRC Form 102: Acknowledgement and Consent for Fingerprinting and Disclosure of Criminal History Record Information

NYS Department of Health, Criminal History Record Check Unit
chrc@health.state.ny.us

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

Last Name:	First Name:	Middle Initial:	Maiden Name:
Date of Birth (mm/dd/yyyy)	Alias/AKA:	Mother's Maiden Name:	

Mailing Address (Street):	City:	State:	Zip Code:

SECTION 2 - ATTESTATION

1. I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).
2. I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
3. I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary. In accordance with applicable laws, DOH will furnish appropriate summary information to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law. I have been informed that upon receiving notification from DCJS that there is a subsequent pending criminal action or proceeding or conviction, the DOH shall promptly notify an authorized person(s) of a provider of the additional allegation or new conviction.
4. I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.
5. I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures by the DCJS and the FBI. If I believe an error has been made by DCJS for any New York State conviction/charge or the FBI for any non-New York State conviction/charge, I understand that I should notify DCJS and/or the FBI to report and request correction of this error to the addresses below.

NYS Division of Criminal Justice Services Criminal History Bureau Record Review Unit – 5th Floor 4 Tower Place Albany NY 12203 (518) 485-7675	Federal Bureau of Investigation Criminal Justice Information Services (CJIS) Division 1000 Custer Hollow Road Clarksburg WV 26306

6. I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.
7. I certify to the best of my knowledge and belief that I (check as appropriate):
   - ☐ **Have** ☐ **Have not been convicted of a crime in New York State or any other jurisdiction**
   - ☐ **Do** ☐ **Do not have a final finding of patient or resident abuse**

   If you checked either "Have" and/or "Do", please provide a brief explanation. (Optional)
   _____
8. My current mailing or home address is indicated in Section 1 of this form.
9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the re-disclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency in accordance with applicable laws. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own.

Applicant Signature: _____ Date: _____/_____/_____

Name and Signature of Parent or Legal Guardian: _____ Date: _____/_____/_____
(if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name: St. Johnsville Rehabilitation & Nursing Center, Inc.	Operating License Number (PFI): 4107
Print Name of Authorized Person: Hope E. Achzet	Title: Human Resource Director
Signature of Authorized Person:	Date: