

CROUSE COMMUNITY CENTER • MORRISVILLE, NEW YORK 13408

EQUAL OPPORTUNITY AFFIRMATIVE ACTION EMPLOYER

APPLICATION FOR EMPLOYMENT

Please fill out this form fully, accurately, and in your own handwriting. Your cooperation will help us deal with your application more effectively. A personnel interview will be requested, providing there is an opening meeting your qualifications.

Position applied for _____ Date _____

Name (Print) _____
LAST FIRST MIDDLE

Present Address _____
STREET CITY STATE ZIP CODE

How long at present address? _____ Telephone _____

Previous address _____
STREET CITY STATE

How long at previous address? _____ Social Security No. _____

Have you ever had a name change? Yes No If so, please list. _____

*Are you over 18 and under 65? _____ U.S. Citizen Yes No

*NOTE: Federal and State Human Rights laws prohibit discrimination in employment because of age, sex, national origin, race, color, creed, disability, marital status or handicap.

Have you ever been convicted of an unlawful offense (Exclude traffic violations)? _____

If yes, please explain _____

Did you serve in U.S. Armed Forces? Yes No From _____ To _____

Branch of service _____

In case of emergency, notify _____ Telephone _____

Relationship _____

Address _____

Have you submitted an application previously? Yes No

Have you ever worked for this facility before? Yes No If so, when? _____

Are you presently employed? Yes No If so, reason for desiring change _____

_____ May we refer to your present employer? Yes No

Starting salary or wages expected _____ Date Available _____

EDUCATION

Circle highest grade completed 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

	Name of School	Location	Dates Attended		Diploma or Degree
			From	To	
Grammar					
High School					
College					
School of Nursing					
Technical or Business					
Other Skills	Typing Speed	Short Hand	Business Machines		

Membership in Professional Organizations (List):

THIS SECTION TO BE COMPLETED BY PROFESSIONAL AND LICENSED PRACTICAL NURSE APPLICANTS ONLY

Are you presently licensed to practice in New York State? Yes No Expiration Date _____ Date of Last Renewal _____

Registration number _____ Are you registered in another state? Yes No

Name of state _____ Registration number _____

If not licensed, please indicate permit status. _____

What are your preferences of service?

THIS SECTION FOR CERTIFIED NURSING ASSISTANTS ONLY

Are you currently registered in New York State Yes <input type="checkbox"/> No <input type="checkbox"/>	Give number	If not, have you applied Yes <input type="checkbox"/> No <input type="checkbox"/>	In what other states are you registered
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PERSONAL REFERENCES

Give the names of three persons, NOT RELATIVES OR EMPLOYERS, who have known you for several years:

Name	Address	Occupation

PREVIOUS POSITIONS HELD

List last 4 positions, giving last position first:

Employer _____ Address _____

Position _____ Employed from _____ to _____

Salary _____ Reason for leaving _____

Person to be contacted for reference _____ Title _____

Employer _____ Address _____

Position _____ Employed from _____ to _____

Salary _____ Reason for leaving _____

Person to be contacted for reference _____ Title _____

Employer _____ Address _____

Position _____ Employed from _____ to _____

Salary _____ Reason for leaving _____

Person to be contacted for reference _____ Title _____

Employer _____ Address _____

Position _____ Employed from _____ to _____

Salary _____ Reason for leaving _____

Person to be contacted for reference _____ Title _____

LIST ADDITIONAL WORK EXPERIENCE _____

EMPLOYMENT AGREEMENT

I understand that any false statements made as a part of this application will be considered sufficient cause for dismissal. I also grant permission for the authorities of the CROUSE COMMUNITY CENTER to investigate any and all information and release said hospital from any and all liability resulting from such investigation.

I understand that employment at CROUSE COMMUNITY CENTER means that at any time when deemed necessary, I may be required to work rotating shifts or change my regular shift (if applicable) upon reasonable request.

I consent to any and all job related medical examinations required by the hospital and understand that if I am employed I will be on the applicable probationary period from date of employment. Upon my termination I authorize the release of reference information on my work.

SIGN YOUR NAME

