ST. JOHNSVILLE REHABILITATION AND NURSING CENTER
Employment Application

7 Timmerman Ave
St. Johnsville, NY 13452
Phone: (518) 568-5037
Fax: (518) 568-5477
www.stjrnc.com

APPLICANT INFORMATION			
Last Name:	First (full):	M.I.:	Date:
Street Address:		Apartment/Unit #:	
City:	State:	ZIP:	
Phone:	Alternate Contact #:		

Social Security #:	Professional License/Certificate No.:
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 ☐	*If yes, an explanation will be requested upon interview*

Applicant Referred: NEWSPAPER ☐ CURRENT EMPLOYEE ☐ _____		OTHER ☐_____
Position Applied for:	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/Cert. Program:			Name of Institution:
Did you graduate?	YES ☐	NO ☐	Street Address:
Degree:			City, State, Zip:

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:
Starting Salary:$ / Current Salary:$	Start Date: / End Date:
Reason for seeking employment elsewhere:	

PREVIOUS EMPLOYMENT

Company:	Phone: ( )
Street Address:	
Job Title:	Supervisor:
Starting Salary:$ / Ending Salary:$	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:
Starting Salary: $ / Ending Salary: $	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:
Starting Salary: $ / Ending Salary:$	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 and Nursing Center is an equal opportunity employer. Discrimination is prohibited based on race, color, creed, religion, national origin, age, sex, sponsor, disability, marital status, or sexual preference.

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.

Signature:	Date:

St. Johnsville Rehabilitation and Nursing Center

Welcome to the St. Johnsville Rehabilitation and Nursing Center. It is our pleasure to welcome you as new member of our team. In order to ensure that our residents' receive the highest quality services by those suited for employment within the skilled nursing setting all non-licensed personnel are subject to the New York state Department of Health Criminal History Record Check Program (CHRC). **Participation is required as dictated by the DOH program requirements.** Having been selected to fill a position opening in our facility you will be required to submit to a "Live Scan" prior to and as a condition of participation in General Orientation. You will be considered a prospective employee until such time that the CHRC program participation is complete.

Upon offer of employment with the St. Johnsville Rehabilitation and Nursing Center the below outlined must be fulfilled as a condition of employment.

- An appointment will scheduled to meet with facility's HR representative. **Attendance is mandatory.** Please have the following information available upon reporting for your scheduled appointment:
    - Social Security Number
    - Personal Identifying Information (height, weight, etc)
    - Any/all information pertaining to criminal convictions
    - *For those under the age of 18 years informed parental consent is required. For those prospective employees, a 102 Consent form will be provided prior to meeting with HR.* ***Program participation is strictly prohibited without parental consent.***
- For those who have previously submitted to the CHRC program with a previous employer, upon confirmation by the CHRC unit, general orientation will be scheduled.
- For those who are considered "new" to the CHRC program a "Live Scan" will be required. The facility's HR representative will contact those individuals by phone to determine their availability.
    - "Live Scan" services are provided by L-1 Identity Solutions
    - Payment is the responsibility of the St. Johnsville Rehabilitation & Nursing Center.
    - Sites are available in Herkimer, Montgomery and Fulton counties. Site selection is based on the individuals' preference. **It the prospective employee's responsibility to secure transportation to and from the appointment.**
- HR will contact the prospective employee with the date and time he/she is required to report for the "Live Scan".
- Upon completion of the "Live Scan" the prospective employee will be provided a receipt. This receipt serves as proof of the completion of the requirements of the CHRC program and must be presented upon reporting for General Orientation. **You will not be permitted to participate in General Orientation without the "Live Scan" Receipt.**

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

Reference Authorization

I hereby voluntarily consent to allow the **St. Johnsville Rehabilitation and Nursing Center**, 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:

DEPARTMENT: _____ ATTENTION: _____

DATE SENT: _____ DATE RECEIVED:_____

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 information 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 established 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	Operating License Number (PFI): 4107
Print Name of Authorized Person: Robin Wentworth	Title: HR Director
Signature of Authorized Person:	Date:

St. Johnsville Rehabilitation and Nursing Center

CHRC Data Entry Form

Please Print, One Letter per Box

First Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle Initial: ☐

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

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

Maiden Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Alias (AKA): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Street Number: ☐☐☐☐☐☐

Street Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

State: ☐☐

Zip Code: ☐☐☐☐☐

Apartment Number: ☐☐☐☐☐☐

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

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

Birth Country: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(see reverse)

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 or 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: ☐☐☐

Name: _____

Please circle the location and time frame that you would like to have your finger prints done and return with CHRC consent form:

Locations:

- Johnstown
- Herkimer
- Cobleskill
- Schenectady
- Saratoga Springs

Time of day that works best:

- 8AM to 12N
- 12N to 3PM

You will be notified with date and time of appointment once scheduled

St. Johnsville
Rehabilitation & Nursing Center, Inc.

I AUTHORIZE THE RELEASE OF INFORMATION ON MY CHARACTER AND JOB PERFORMANCE TO ST. JOHNSVILLE REHABILITATION & NURSING CENTER, INC.

DATE _____ SIGNATURE OF APPLICANT _____

TO: _____ RE: _____

_____ SOC. SEC. NO _____

DATES

_____ EMPLOYED _____

_____ POSITION HELD _____

The above named individual has applied for work with our organization and has signed this authorization for the release of information requested below. Please complete the following areas:

Work Reference _____ Personal Reference _____ Thank you.

☐ **WORK**

Are the employment dates listed above correct? Yes _____ No _____

If no, please list correct dates: _____ to _____

Reason for leaving _____

Would you rehire this employee? Yes _____ No _____ If No, why? _____

Please rate the applicant on the following:	Above Average	Average	Below Average
QUALITY OF WORK PERFORMED			
RELATIONSHIP WITH OTHERS			
HONESTY			
COOPERATION			
GROOMING			
DEPENDABILITY			
ATTENDANCE			
OVERALL RATING			

☐ **PERSONAL**

How well do you know the applicant named above? _____slightly _____ well _____ very well

What is your relationship to the applicant? _____

Reason for leaving _____

How long have you known the applicant? _____ years.

Please rate the applicant on the following:	Above Average	Average	Below Average
QUALITY OF WORK PERFORMED			
RELATIONSHIP WITH OTHERS			
HONESTY			
COOPERATION			
GROOMING			
DEPENDABILITY			
ATTENDANCE			
OVERALL RATING			

COMMENTS: _____

_____

Signature: _____ Title _____ Date _____

St. Johnsville
Rehabilitation & Nursing Center, Inc.

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DATE _____ SIGNATURE OF APPLICANT _____

TO: _____ RE: _____

_____ SOC. SEC. NO _____

DATES

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COOPERATION			
GROOMING			
DEPENDABILITY			
ATTENDANCE			
OVERALL RATING			

☐ **PERSONAL**

How well do you know the applicant named above? _____slightly _____ well _____ very well

What is your relationship to the applicant? _____

Reason for leaving _____

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QUALITY OF WORK PERFORMED			
RELATIONSHIP WITH OTHERS			
HONESTY			
COOPERATION			
GROOMING			
DEPENDABILITY			
ATTENDANCE			
OVERALL RATING			

COMMENTS: _____

_____

Signature: _____ Title _____ Date _____

St. Johnsville
Rehabilitation & Nursing Center, Inc.

I AUTHORIZE THE RELEASE OF INFORMATION ON MY CHARACTER AND JOB PERFORMANCE TO ST. JOHNSVILLE REHABILITATION & NURSING CENTER, INC.

DATE _____ SIGNATURE OF APPLICANT _____

TO: _____ RE: _____

_____ SOC. SEC. NO _____

DATES

_____ EMPLOYED _____

_____ POSITION HELD _____

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RELATIONSHIP WITH OTHERS			
HONESTY			
COOPERATION			
GROOMING			
DEPENDABILITY			
ATTENDANCE			
OVERALL RATING			

☐ **PERSONAL**

How well do you know the applicant named above? _____slightly _____ well _____ very well

What is your relationship to the applicant? _____

Reason for leaving _____

How long have you known the applicant? _____ years.

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QUALITY OF WORK PERFORMED			
RELATIONSHIP WITH OTHERS			
HONESTY			
COOPERATION			
GROOMING			
DEPENDABILITY			
ATTENDANCE			
OVERALL RATING			

COMMENTS: _____

_____

Signature: _____ Title _____ Date _____