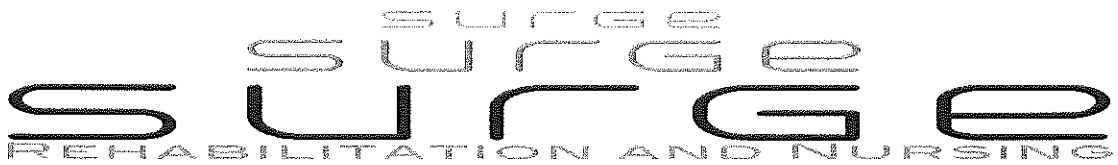

49 Oakcrest Ave • Middle Island • NY, 11953

Phone :(631)995-2900 Fax: (631) 995-2702

Dear Employee:

Please fill out and sign all documents in this packet. You are also required to provide the following documentation:

- Application
- (2) References
- Physical
- PPD
- Flu shot
- Immunization
- MMR Titers
- Driver's License
- Social security card
- Professional License/Certificate (If applicable)
- CPR Certificate (If Applicable)
- Other: _____

Thank You

Rosa Donza

Administrative Assistant

surge

surge

REHABILITATION AND NURSING

APPLICATION FOR EMPLOYMENT

It is the policy of Surge Rehabilitation and Nursing to provide employment training, compensation, promotion and other conditions of employment without discrimination on the basis of race, color, sex, citizenship, national origin, ancestry, Vietnam era veteran status, or on the basis of age or physical or mental disability unrelated to ability to perform the work required. No question on this application is intended to secure information to be used for such discrimination.

_____ _____

Signature Date

_____ _____

Print Name Date

Note: Please be advised that upon offer of employment you will be required to submit the following documentation on Orientation, if not submitted prior:

- Proof of eligibility to work (Driver's License, S.S. Card, Professional License if applicable, etc.)
- Current Physical Examination
- Immunization Records
- PPD/Mantoux Records

FOR OFFICE USE ONLY
(Please choose all that apply)

	Status:	Shift:
Accept	FT PT	7-3
		3-11
Deny	Per Diem	11-7
Salary: _____	Sigma Experience Yes No	

Comments: _____

Surge Rehabilitation & Nursing

Employee Profile

Name: _____

Address: _____

_____

Social Security #: _____ Date of Birth: _____

Phone #: _____ Alt Phone#: _____

e-mail: _____

Date of Hire: _____ Orientation: _____

Dept/Position Hired for: _____

Status Hired (FT/PT/Per Diem): _____

Shift Hired for: _____

Certificate/License#: _____

Surge Rehabilitation and Nursing

AFFIRMATION OF APPLICANT FOR PROVISIONAL EMPLOYMENT

I, _____ hereby state as follows:

1. I acknowledge that prior to being offered provisional employment with ***Surge Rehabilitation and Nursing***, pursuant to the NYS Department of Health's Criminal History Record Checks Regulations set forth under Title 10, Section 400.23 of the New York Code of Rules and Regulations ("Criminal History Regulations"),employment offers are contingent upon the afore mentioned information. I must complete this statement
2. I certify that (Please check one)

   ☐ There have been no prior findings by any governmental agency or regulatory body of patient or resident abuse against me, nor do I have any open criminal charges and/or been convicted of a crime or violation other than a traffic infraction.

   ☐ There has been a prior finding of patient or resident abuse against me by a governmental agency or regulatory body, and/or I have been charged and/or convicted of a crime or violation other than a traffic infraction, as explained below

   _____

   _____

   _____

   _____

3. I understand that as a part of satisfying the requirements of the Criminal History Regulations, the Attorney General of the United States will conduct a full search of all the records of the Federal Bureau of Investigation to ascertain if I have any record of a criminal conviction. If the search reveals I have been convicted of certain enumerated crimes, my employment with **Surge Rehabilitation and Nursing** will be terminated.

I have read the above statements. I fully understand its contents and I certify it is true and correct to the best of my knowledge and belief.

Signature _____

Date _____

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Date Available: _____ Social Security No.: _____ Desired Salary: $ _____

Position Applied For: _____

Full time: _____ Part Time: _____ Week Days And/or Shift: _____

Are you under 18 years of age? Yes☐ No☐ If yes, do you have a work permit? Yes☐ No☐

Are you a Citizen of the U.S.? Yes☐ No☐ If no, do you have the legal right to remain permanently in the United States? Yes☐ No☐

If hired, can you provide verification of your legal right to work in the United States? Yes☐ No☐

If hired, would you have reliable transportation to and from work? Yes☐ No☐

Have you ever worked for this facility before? Yes☐ No☐ If yes, please provide dates of employment, as well as the position held during this time: DATES: _____ POSITION: _____

Do you have friends or relatives working for our company? Yes☐ No☐

If yes, state name and relationship to you: _____

Do you have any open criminal charges and/or have been convicted of any criminal offenses, including but not limited to, being found guilty by a court of law of abusing, neglecting or mistreating residents or misappropriating resident belongings? Yes☐ No☐

If yes, state offense, date, and location:

_____

_____

_____

_____

_____

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? Yes ☐ No ☐ Diploma:: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? Yes ☐ No ☐ Degree: _____

Other: _____ Address: _____

From: _____ To: _____ Did you graduate? Yes ☐ No ☐ Degree: _____

Skills

(For all Licensed/Certified Personnel)

License Type: _____ License Number/State: _____

License Expiration Date: _____

Certificate Type: _____ Certificate Number/State: _____

Certificate Expiration Date: _____

What foreign languages do you speak fluently, if any? _____

Do you have any experience, training, or qualifications which you think make you especially suited for work at this company? _____

_____

References

Please list three personal references.

Name: _____ Relationship: _____

Contact Information: _____

Name: _____ Relationship: _____

Contact Information: _____

Name: _____ Relationship: _____

Contact Information: _____

Previous Employment

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary:$ _____ Ending Salary:$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? Yes ☐ No ☐

_____

_____

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary:$ _____ Ending Salary:$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? Yes ☐ No ☐

_____

_____

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary:$ _____ Ending Salary:$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? Yes ☐ No ☐

Are there any gaps in employment history? ☐Yes ☐ No

If so, please explain why: _____

_____

_____

Employment Understanding and Acknowledgment

1. I voluntarily give Surge Rehabilitation and Nursing the right to conduct a thorough investigation of my past employment and activities. I agree to cooperate in such investigation and release from all liability or responsiblity all persons, companies or corporations supplying such information.

2. I understand that as a condition of employment I may be required to take a pre-employment physical examination. I further understand that Surge Rehabilitation and Nursing may require a physical examination be conducted at request of facility. I understand that an offer of employment may be contingent on passing the physical examination which relates to the essential duties I would be required to perform.

3. I understand that all offers of employment are conditioned upon my providing satisfactory documentary proof of my identity and legal right to live and work in the United States. If employed, I will have to show satisfactory evidence of identity and eligibility for employment at orientation.

4. I understand that my employment is "at will" and that either party is free to terminate the employment relationship at any time without cause. I further understand that if my employment should be terminated, the obligation of the facility to pay salary or wages to be shall end with the last date actually worked by me.

5. I certify that all statements made in the foregoing application are true and complete to the best of my knowledge, and the facility may investigate such statements. I understand that id employed, falsified statements or omission of facts appearing on the application shall be considered sufficient cause for dismissal, if discovered at a later date.

_____ _____

Signature of Applicant **Date**

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REHABILITATION AND NURSING

CONFIDENTIAL REFERENCE REQUEST

Date: _____

Applicant: _____

Last 4 digits of SS#: _____

To Whom It May Concern,

The above named applicant has indicated that he/she was previously employed by you. Your evaluation of him/her will be sincerely appreciated, and will be held completely in confidence. Both the applicant and our facility will greatly benefit from an early reply. ***Please fax back to 631.995-2702 ATTN: Rosa***

Thank you,

Rosa Donza
Administrative Assistant

Applicant Signature

Applicant Name: _____

Dates of Employment: _____

Position at start of employment: _____

Position at end of employment: _____

Reason for leaving: _____

Eligible for Re-Hire: ☐ Yes ☐ No

If not, please explain: _____

Quality of work:	☐ Good	☐ Adequate	☐ Poor
Productive output:	☐ Good	☐ Adequate	☐ Poor
Attendance:	☐ Good	☐ Adequate	☐ Poor
Cooperation:	☐ Good	☐ Adequate	☐ Poor
Initiative:	☐ Good	☐ Adequate	☐ Poor
Personal Appearance:	☐ Good	☐ Adequate	☐ Poor

Other comments *(your remarks are the most important part of this questionnaire)*

_____

_____

_____

Signature of Agency Representative Title Date

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REHABILITATION AND NURSING

CONFIDENTIAL REFERENCE REQUEST

Date: _____

Applicant: _____

Last 4 digits of SS#: _____

To Whom It May Concern,

The above named applicant has indicated that he/she was previously employed by you. Your evaluation of him/her will be sincerely appreciated, and will be held completely in confidence. Both the applicant and our facility will greatly benefit from an early reply. ***Please fax back to 631.995-2702 ATTN: Rosa***

Thank you,

Rosa Donza
Administrative Assistant

Applicant Signature

Applicant Name: _____

Dates of Employment: _____

Position at start of employment: _____

Position at end of employment: _____

Reason for leaving: _____

Eligible for Re-Hire: ☐ Yes ☐ No

If not, please explain: _____

Quality of work:	☐ Good	☐ Adequate	☐ Poor
Productive output:	☐ Good	☐ Adequate	☐ Poor
Attendance:	☐ Good	☐ Adequate	☐ Poor
Cooperation:	☐ Good	☐ Adequate	☐ Poor
Initiative:	☐ Good	☐ Adequate	☐ Poor
Personal Appearance:	☐ Good	☐ Adequate	☐ Poor

Other comments *(your remarks are the most important part of this questionnaire)*

_____

_____

_____

Signature of Agency Representative Title Date

DOH CHRC 102 (1/07)

NYS Department of Health
ACKNOWLEDGEMENT AND CONSENT FORM FOR FINGERPRINTING AND DISCLOSURE OF CRIMINAL HISTORY RECORD INFORMATION

THIS FORM IS TO BE RETAINED BY THE AGENCY- DO NOT FORWARD TO THE DOH CHRC 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	M.I.	
Date of Birth (mm/dd/yyyy)	Mother's Maiden Name	Alias: AKA	

Mailing Address (street)	City	State	Zip

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 to be provided 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, as maintained by DCJS or the FBI, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. I have been advised that by law, DOH is authorized and may be required to provide the results of the criminal history record check through a criminal history record summary to the agency. 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.

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.

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 have 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 redisclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency. 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 (not applicable for Expedited Review submitted pursuant to CHRC Form 104).

Applicant Signature: _____ Date: _____

Signature of Parent or Legal Guardian_____ Date: _____
(If subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name:	PFI/Operating License Number:
Print Name of Authorized Person:	Title:
Signature of Authorized Person:	Date:

NYS Department of Health	REQUEST FOR CRIMINAL HISTORY RECORD CHECK PAGE 1 INSTRUCTIONS	
CHRC Unit P. O. Box 2607 Albany, NY 12220-0607 Phone: 518.402.5549 Fax: 518.474.7477 www.nyhealth.gov/chrc chrc@health.state.ny.us	CRIMINAL HISTORY RECORD CHECK (CHRC) PROGRAM	*For Department use only* *Leave blank*

This form is to be used to request a criminal history record check (CHRC) for a subject individual from the DOH CHRC Unit.

For purposes of this form, the term **"Agency"** means residential health care facility, certified home health agency, licensed home care services agency or long term home health care programs that are authorized by law to request a check of criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.
"Authorized Person" is the individual that is allowed to request, on behalf of the Agency, fingerprints and criminal history record checks.
"Subject Individual" is an "employee" as defined by Public Health Law Section 2899(3).

INSTRUCTIONS:

1. This form is to be completed by the Authorized Person, who will sign and date where indicated in Section 3.
2. Please obtain subject individual information and complete all sections on page 2 of this form prior to or at the time of fingerprinting. This information will be used to conduct both a Federal and State criminal history record check pursuant to State law.
3. If subject individual is employed by a staffing organization with an Agency work location, the Agency is responsible for completing this form and the staffing agency may complete Section 4 if that staffing agency fingerprints the subject individual.
4. Subject individual is required to present two (2) forms of identification (ID) when fingerprinted. One must be a government-issued ID with subject individual's signature. At least one of the two forms of ID must contain a current photograph. Acceptable forms of government-issued IDs are: valid driver's license or Department of Motor Vehicles (DMV) ID, valid passport, valid military identification or valid school identification document. The type of government-issued ID presented is recorded in Section 2 of this form. Refer to the Employment Eligibility Verification Form I-9 for examples of other forms of identification. The second ID must be produced but not recorded in Section 2 of this form.
5. If subject applicant is fingerprinted by other than the Authorized Person, provide this instructional page to that individual for assistance in completing Section 4 of this form.
6. Authorized Person is to ensure that all fields in all sections must be completed for accurate and timely submissions.
7. Authorized Person will forward Page 2 of this Form to the DOH CHRC Unit at the address indicated above.

FIELD DESCRIPTIONS:

SEX FIELD
M – Male
F – Female

RACE FIELD
A – Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan or any other Pacific Islander
B – African black racial groups
I – American Indian, Eskimo, or Alaskan native
U – Of indeterminable race
W – Caucasian, Mexican, Puerto Rican, Cuban, Central/South American or other Spanish origin

BIRTH COUNTRY/PLACE FIELD
Enter **United States of America** for those of American birth
Enter Country of Birth for those not of American birth

HEIGHT FIELD
To be completed as a three (3) character value. If reported in feet and inches, the first (leftmost) digit is used to show feet with the two rightmost digits are used to show the inches between 00 and 11. If reported in inches, the leftmost character is "N" followed by two digits. If height in unknown, 000 is entered.

The allowable range is 400 to 711. Heights shorter than 4 ft. will be recorded as 400 and taller than 7 ft. 11 in. will be recorded as 711.

WEIGHT FIELD
In this field, the subject applicant's weight in pounds is entered (000-499). If weight is unknown, 000 is entered.
All weight in excess of 499 pounds will be recorded as 499 lbs.

HAIR FIELD – COLOR CODES
BAL – Bald
BLK – Black
BLN – Blonde or Strawberry
BLU – Blue
BRO – Brown
GRN – Green
GRY – Gray or Partially Gray
ONG – Orange
PNK – Pink
PLE – Purple
RED – Red or Auburn
SDY – Sandy
WHI – White
XXX – Unknown

EYE FIELD – COLOR CODES
BLK – Black
BLU – Blue
BRO – Brown
GRY – Gray
GRN – Green
HAZ – Hazel
MAR – Maroon
MUL – Multicolored
PNK – Pink
XXX – Unknown

NYS Department of Health | **CRIMINAL HISTORY RECORD CHECK**

Resubmission ○

Type or print all information - USE CAPITAL LETTERS.
Inaccurate, incomplete or illegible information will delay processing.

DOH use only. Leave blank

SECTION 1 - SUBJECT INDIVIDUAL INFORMATION

Social Security Number* ___ - ___ - ____ Date of Birth mm/dd/yyyy __ / __ / ____

LAST Name _____ FIRST Name _____ M.I. _

Malden Name _____ Alias (AKA) _____

Street Nmbr _____ Street Name _____ Apt # _____

City _____ St __ Zip _____ Home Phone ___ - ___ - ____

Sex _ Birth Country/Place _____ Cell Phone ___ - ___ - ____

Race _ Height (ft-inch) _ - __ Weight (lbs) ___ Hair ___ Eyes ___

SECTION 2 - SUBJECT INDIVIDUAL IDENTIFICATION

Please Select the Type of **PICTURE IDENTIFICATION** (select one):

○ Drivers License/ DMV ID ○ Passport ○ Military ○ School ○ Other Identify: _____

Issuing State/Country/Armed Force/School: _____ ID Number _____ ID Expire Date mm/dd/yy __ / __ / __

SECTION 3 - AGENCY IDENTIFICATION

○ Nursing Home ○ CHHA ○ LTHHCP PFI# ____ ○ LHCSA LICENSE # _____

Full name of Agency where applicant will be working _____ Telephone number with area code ___ - ___ - ____

Authorized Person LAST Name _____ FIRST Name _____

Agency's Street Nmbr _____ Street Name _____

City _____ State __ Zip _____

Authorized Party's e-mail: _____

The subject individual, whose identification I have confirmed, will provide direct care or supervision to individuals receiving care and/or services and is a subject individual concerning whom a criminal history record check is required by law (Article 28-E of the Public Health Law and Section 845-B of the Executive Law). I understand that the results of the criminal history record check will be used solely for purposes authorized by law and I will abide by the confidentiality requirements set forth in law. Informed consent (DOH CHRC Form 102) has been given by the subject individual and is on file.

Signature of Agency Authorized Person: _____ Date: __ / __ / __ (MM / DD / YY)

SECTION 4 - FINGERPRINTING METHOD/IDENTIFICATION

Fingerprint Method:
○ Ink & Roll
○ Live Scan

Name & Address of Location where fingerprint services were performed _____

City _____ State __ Zip _____

Identification verified before fingerprinting: (refer to Instruction #4)
○ Yes
○ No

The subject individual, whose identification I have confirmed, appeared before me for fingerprinting. I secured his/her fingerprints via the method indicated.

Signature: _____

First Name: _____

Last Name: _____

Title: _____

Date Fingerprinted __ / __ / ____ (MM / DD / YYYY)

51289

*The Authorized Person shall inform the subject individual that disclosure of the Social Security Number (SSN) is voluntary and not mandatory and that it will be used to assist DOH-CHRC Unit in performing criminal history record checks.