



United Cerebral Palsy Association of Greater Suffolk, Inc.
 250 Marcus Boulevard, PO Box 18045, Hauppauge, New York 11788-8845
APPLICATION FOR EMPLOYMENT

PLEASE TYPE OR PRINT ALL INFORMATION IN INK. USE AND ATTACH ADDITIONAL PAGES IF REQUIRED.

Position Applied For: _____ Date of Application: _____

How Did You Learn About Us?
 Advertisement Internet Friend Relative Walk-In Other _____
 Employee referral (*Print Name of Employee*) _____

_____ Last Name First Name Middle Name
 _____ Street Address
 _____ City State Zip Code

Daytime Telephone Number - -	Evening Telephone Number - -	Social Security Number - -
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Yes No If you are under 18 years of age, can you provide required proof of your eligibility to work?

Yes No Are you prevented from lawfully becoming employed in this country because of Visa or Immigration Status? (*Proof of citizenship or immigration status will be required upon employment*)

Yes No Have you ever filed an application with us before? If yes, give date _____

Yes No Have you ever been employed with us before?
 If yes, give dates and position held: _____

Yes No Are you currently employed? If yes, may we contact your present employer? _____

Yes No Do you have any prior or current experience as an employee, volunteer, or certified provider with OMRDD; any other State Agency; or any other provider of human services?
 If yes, Please explain: _____

Yes No Do you have any prior or current experience in direct care work relevant to the position for which you are applying? (*Note any child-care experience.*)
 If yes, please explain: _____

Yes No Have you ever been convicted of a crime including a felony or misdemeanor?
 If yes, please explain: _____

Yes No Are any criminal charges currently pending against you?
 If yes, please explain: _____

Yes No Have you ever been investigated or convicted of Medicaid fraud?
 If yes, please explain: _____

Yes No Were you ever fired by a former employer for abuse or neglect of a person with disabilities?
 If yes, please explain: _____

Yes No Are you available to work (*check all that apply*)? Full Time Part Time Shift Work

On what date would you be available to start? _____

What shift are you available to work (check all that apply): Days Evenings Overnights Weekends

EDUCATION

	SCHOOL Name, Address, and Telephone #	Course of Study	Years Completed	Diploma Degree Received
High School			1 2 3 4 (Check)	
Undergraduate College			1 2 3 4 (Check)	
Graduate Professional			# Credits Completed _____	
Other (Specify)			1 2 3 4 (Check)	

DESCRIBE ANY SPECIALIZED TRAINING, APPRENTICESHIP SKILL, AND EXTRA-CURRICULAR ACTIVITIES:

DESCRIBE ANY JOB-RELATED TRAINING RECEIVED IN THE UNITED STATES MILITARY:

MOTOR VEHICLE

If the position you are applying for requires that you drive an Agency Vehicle, please complete the following questions:

Do you have a valid New York State Drivers License? Yes No

What is the Identification Number on your license?

Have you had any moving violations within the past three years or suspensions, revocations, D.W.I. Convictions or any occurrences regarding harm to persons or property while driving? Yes No

If yes, please explain (include dates and complete description):

ADDITIONAL TRAINING OR EXPERIENCE

Other Qualifications

SUMMARIZE SPECIAL JOB-RELATED SKILLS AND QUALIFICATIONS ACQUIRED FROM EMPLOYMENT OR OTHER EXPERIENCE:

Computer Skills *(Check)*

Microsoft Windows XP	Microsoft Windows 2000	Microsoft PowerPoint—Version _____
Microsoft Excel—Version _____	Internet Explorer—Version _____	Microsoft Publisher—Version _____
Microsoft Word—Version _____	Vista —Version _____	Programming Skills
Outlook —Version _____	Crystal Reports	HTML

Accounting Software

Great Plains/Dynamics—Version _____
 ADP for Windows—Version _____
 Other _____

Networking

Windows 2000 Server
 Windows 2003 Server

REFERENCES

Please supply the names, addresses, and telephone numbers of a minimum of two (2) individuals not related to you who can attest to your character, reputation, and personal qualifications.

NAME	ADDRESS	TELEPHONE NUMBER
		()
		()

Please supply the names, addresses, and telephone numbers of individuals not related to you who can verify your history of employment or related experience, work record, and qualifications related to the care or services of individuals with developmental disabilities.

NAME	ADDRESS	TELEPHONE NUMBER
		()
		()

EMPLOYMENT EXPERIENCE

Start with your present or last job. Include any job-related military service assignments and volunteer activities. You may exclude any organizations which indicate race, color, religion, gender, national origin, disabilities or other protected status.

CURRENT OR MOST RECENT POSITION

Employer		Dates Employed		Work Performed
		From	To	
Address				
Telephone Number(s)		Hourly Rate/Salary		
Job Title	Supervisor	Starting	Final	
Reason for Leaving				

NEXT RECENT POSITION

Employer		Dates Employed		Work Performed
		From	To	
Address				
Telephone Number(s)		Hourly Rate/Salary		
Job Title	Supervisor	Starting	Final	
Reason for Leaving				

NEXT RECENT POSITION

Employer		Dates Employed		Work Performed
		From	To	
Address				
Telephone Number(s)		Hourly Rate/Salary		
Job Title	Supervisor	Starting	Final	
Reason for Leaving				

NEXT RECENT POSITION

Employer		Dates Employed		Work Performed
		From	To	
Address				
Telephone Number(s)		Hourly Rate/Salary		
Job Title	Supervisor	Starting	Final	
Reason for Leaving				

If you need additional space, please continue on a separate sheet of paper.

OTHER INFORMATION

LIST PROFESSIONAL, TRADE, BUSINESS, OR CIVIC ACTIVITIES, AND OFFICES HELD. *You may exclude membership which would reveal gender, race, religion, national origin, age ancestry, disability, or other protected status.*

STATE ANY ADDITIONAL INFORMATION YOU FEEL MAY BE HELPFUL TO US IN CONSIDERING YOUR APPLICATION.

APPLICANT'S STATEMENT

I certify that the information contained in this application is true and complete to my knowledge.

I authorize investigation of all matters contained in this application for employment as may be necessary in arriving at an employment decision.

I understand and agree that any misleading or false statement would be cause for non-employment or would be sufficient cause for dismissal after my employment.

I understand that my employment is contingent upon the receipt by United Cerebral Palsy Association of Greater Suffolk, Inc. (UCP) of satisfactory work references. I hereby authorize my present/past employers to furnish UCP with their records of service. I agree if employed to supply UCP with such verifications as may be permitted by Federal or State codes and regulations.

I understand that I may be subject to a criminal history record check, fingerprinting, Medicaid fraud check, drug screening, motor vehicle license check and/or sex offender registry check.

I understand, also, that I am required to abide by all UCP rules, regulations and policies.

I further acknowledge that this application is not a contract of employment and that unless I am employed pursuant to a collective bargaining agreement or written employment contract that provides to the contrary, I will remain an employee "at will" subject to termination without restriction, cause, or limitation.

Signature of applicant

Date

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NOTE: Applications for employment shall be considered active for a period of time not to exceed 45 days. Beyond this time the applicant must complete a new application.

We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital, military or veteran status, sexual orientation, or any other legally protected status.