

# CAMPBELL HALL NURSING & REHABILITATION

23 KIERNAN ROAD, CAMPBELL HALL, NEW YORK 10916

(845) 294-8154

## APPLICATION FOR EMPLOYMENT

WE CONSIDER APPLICANTS FOR ALL POSITIONS WITHOUT REGARD TO RACE, COLOR, RELIGION, CREED, GENDER, NATIONAL ORIGIN, AGE, DISABILITY, VETERAN STATUS, SEXUAL ORIENTATION, OR ANY OTHER LEGALLY PROTECTED STATUS

Position Desired:	Shift You Are Available <input type="checkbox"/> Day <input type="checkbox"/> Eve <input type="checkbox"/> Night <input type="checkbox"/> Any			
	<input type="checkbox"/> F/T		<input type="checkbox"/> P/T	
	Date You Can Begin Work _____			
Last Name	First	Middle Initial	Maiden Name	Social Security Number
Street Address				Home Telephone ( )
City	State		Zip	Business Telephone ( )

### PLEASE ANSWER THE FOLLOWING QUESTIONS

Are you legally eligible for employment in the United States?

***Proof of citizenship or immigration status will be required upon employment.***

Yes  No

Are you at least 16 years of age?

Yes  No

If you are under 18 years of age, can you provide proof of your eligibility to work?

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 date \_\_\_\_\_

Yes  No

May we contact your present employer?

Yes  No

May we contact your previous employer(s)?

Yes  No

Were you ever dismissed or discharged from any employment for reasons other than lack of work or funds?

Yes  No

Did you ever resign from any employment rather than face dismissal?

Yes  No

**Except for minor traffic violations and adjudications as youthful offender, wayward minor or juvenile delinquent, have you ever been convicted of any crime?**

Yes  No

### CERTIFIED, LICENSED OR REGISTERED APPLICANTS

(RN's, LPN's, CNA's, etc.)

Are you currently certified, licensed or registered as a health care giver in New York State?  Yes  No

If yes, Certification Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Are you registered in another state  Yes  No If yes, State \_\_\_\_\_ Number \_\_\_\_\_

Have you taken New York State Boards?  Yes  No If yes, date taken \_\_\_\_\_

### ***For Personnel Use Only***

Prometric Web Site checked:: \_\_\_\_\_ Inspector General Web Site Checked \_\_\_\_\_  
(date) (date)

Application cleared through the Nurse Aide Registry Yes  No  Initials: \_\_\_\_\_

Proceed with Application Yes  No  Initials: \_\_\_\_\_

## EDUCATION

SCHOOL	NAME & LOCATION	COURSE OF STUDY	YEARS COMPLETED	DID YOU GRADUATE	DEGREE OR DIPLOMA
ELEMENTARY				<input type="checkbox"/> Yes <input type="checkbox"/> No	
HIGH SCHOOL				<input type="checkbox"/> Yes <input type="checkbox"/> No	
BUSINESS/TRADE/TECH				<input type="checkbox"/> Yes <input type="checkbox"/> No	
COLLEGE				<input type="checkbox"/> Yes <input type="checkbox"/> No	
GRADUATE				<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Experience** – Beginning with your most recent employment and working backward consecutively to your first one, use an additional sheet of paper if necessary. Include Part Time and Full Time Work.

Employer	Dates Employed		Work Performed
	From	To	
	Mo. Yr.	Mo. Yr.	
Complete Address			
Telephone Number	Job Title	Supervisor	
Reason for Leaving			
Employer	Dates Employed		Work Performed
	From	To	
	Mo. Yr.	Mo. Yr.	
Complete Address			
Telephone Number	Job Title	Supervisor	
Reason for Leaving			
Employer	Dates Employed		Work Performed
	From	To	
	Mo. Yr.	Mo. Yr.	
Complete Address			
Telephone Number	Job Title	Supervisor	
Reason for Leaving			

## REFERENCES

Please provide the name, complete address, and phone number of three people **not related to you** that you have known for at least one year. Applications with

1.	_____ Name	_____ Relationship to Applicant	_____ Telephone Number
	_____ Complete Street Address	_____ City	_____ State / Zip
2.	_____ Name	_____ Relationship to Applicant	_____ Telephone Number
	_____ Complete Street Address	_____ City	_____ State / Zip
3.	_____ Name	_____ Relationship to Applicant	_____ Telephone Number
	_____ Complete Street Address	_____ City	_____ State / Zip

**How did you hear about this facility?**  Newspaper  Radio  Current Employee  Other \_\_\_\_\_

**MVNH Employee Referral:** \_\_\_\_\_  
Employee Name Making Referral

## SPECIALIZED SKILLS

<b>Equipment</b> <input type="checkbox"/> Computers <input type="checkbox"/> Network <input type="checkbox"/> Other _____	<b>Computer Software Skills</b> <input type="checkbox"/> Word <input type="checkbox"/> Excel <input type="checkbox"/> Access <input type="checkbox"/> Publisher <input type="checkbox"/> Web Designing <input type="checkbox"/> Other _____	<b>Foreign Language</b> <input type="checkbox"/> Italian <input type="checkbox"/> Polish <input type="checkbox"/> French <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____
Other Skills _____		

## OTHER INFORMATION

Please state any information you feel may be helpful to us in considering your application:

---

---

**CAMPBELL HALL NURSING AND REHABILITATION**  
**23 KIERNAN ROAD, CAMPBELL HALL, NEW YORK 10916 – (845) 294-8154**

I certify that the answers given herein are true and complete to the best of my knowledge. I understand that the employer will thoroughly investigate my work and personal history and verify all data given on this application, on related papers, and in interviews. I authorize all individuals, schools, and firms named therein, except my current employer if so noted, to provide any information requested about me, and I release them from all liability for damage in providing this information.

I understand that, unless otherwise defined by applicable law, any employment relationship with the organization is of an “**at will**” nature, which means that the employee may resign at any time and the employer may discharge employee at any time with or without cause. It is further understood that this “**at will**” employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

I understand this application will be active for a period of three (3) months; after that time if I wish to be considered for employment, I must submit a new application.

I certify that all the statements herein are true and understand that any falsification or willful omission shall be sufficient cause for dismissal or refusal of employment.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date