ORLEANS COUNTY PERSONNEL OFFICE
Orleans County Administration Building
14016 Route 31 West
Albion, NY 14411

(585) 589-3108

Date Received: _____

Fee Received:

$ _____

By: _____

APPLICATION FOR EXAMINATION OR EMPLOYMENT

_____

Title of Position

Application

Approved _____

Disapproved _____*

Conditional _____*

* Reason(s) _____

_____

_____

This Application is valid only when returned to the Orleans County Personnel Office.

INSTRUCTIONS: Answer all questions fully. All qualifying information must be placed on this application. **Resumes may *not* be used to supplement the application.** You should review the minimum qualifications for the position before completing this application. You must provide information showing that you have the necessary training and experience or your application will not be approved. If additional space is needed, please attach additional sheets.

1. NAME, MAILING ADDRESS & PHONE (please print)

_____
Last Name First Name M.I.

_____
Street or Post Office Box Address

_____
City / Town State Zip Code

_____
Home Phone Business Phone

2. SOCIAL SECURITY NUMBER: _____

3. Are you ***under*** 18 years of age? ☐ Yes ☐ No
If YES, or if minimum and / or maximum are limits are established for the position, enter your date of birth:

_____ _____ _____
Month Day Year

4. **VETERAN'S CREDITS** (Exam applicants only)
Do you draw additional credits on this exam as an honorably discharged veteran or conditional credit pending discharge?
- ☐ Yes, as a disabled veteran
- ☐ Yes, as a non-disabled veteran
- ☐ Yes, active duty
- ☐ No

If **YES**, request and complete a veteran's credit form.

5. SPECIAL ARRANGEMENTS (Exam applicants only)
- ☐ Religious Accommodations
- ☐ Disabled Candidate

Indicate needs on a separate sheet of paper

6. Do you have the legal right to accept employment in the United States? ☐ Yes ☐ No

7. State your actual permanent legal residence:
School District: _____
City / Village: _____
Town: _____
County: _____
State: _____

7a. Have you resided at your current address for at least one (1) month? ☐ Yes ☐ No

7b. Have you taken this exam within the last six (6) months? ☐ Yes ☐ No

8a. Were you ever discharged from employment for reasons other than lack of work? ☐ Yes ☐ No

8b. Did you ever resign from employment rather than face dismissal? ☐ Yes ☐ No

8c. If you have service in the U.S. Armed Forces, did you receive a *dishonorable* discharge? ☐ Yes ☐ No

8d. Have you ever been convicted of any crime? (felony or misdemeanor) ? ☐ Yes ☐ No

8e. Have you ever forfeited bail bond posted to guarantee your appearance in court to answer to any criminal charge? ☐ Yes ☐ No

8f. If you answered YES to any question (8a – 8e), provide a complete explanation of the circumstances on a separate sheet of paper including: the date, the parties involved, the facts, and the outcome.

NOTE: A YES answer is not an automatic bar to employment unless otherwise required by law. Each case is considered and evaluated on individual merits in relation to the duties and responsibilities of the position.

THIS AFFIRMATION MUST BE COMPLETED.

I affirm that the statements made on this application (including any attached papers) are true under penalties of perjury.

_____
Signature of Applicant Date

_____
Print any other last names by which you are or have ever been known.

ALL STATEMENTS ARE SUBJECT TO VERIFICATION
SIGNATURE ON LAST PAGE ALSO REQUIRED

02/13/2009

EDUCATION

9a. Have you graduated from High School? ☐ Yes ☐ No

If YES, give the name and location of the high school: _____

If NO, do you have a high school equivalency diploma? ☐ Yes ☐ No

If YES, submit a copy and provide Number: _____

UNDERGRADUATE / GRADUATE EDUCATION

9b.	Name and location of school	Number of years credited	Were you graduated?	Type of course or major	Number of college credits received	Type of degree received	If not graduated, date degree expected
College, University or Technical School							

Other Schools of Special Courses: _____

_____

_____

Please forward an **original College transcript** to this office if required for the Minimum Qualifications.

10. Section 50-b of the New York State Civil Service Law requires that all applicants for examinations be asked the following questions:

Have any loans made or guaranteed by the New York State Higher Education Services Corporation which are currently outstanding? ☐ Yes ☐ No

If so, are you presently in default on any loans? ☐ Yes ☐ No

11. **PROFESSIONAL LICENSES:** If a license, certificate or other authorization to practice a trade or profession is listed as a requirement on the announcement, fill in the following blanks:

If not currently licensed, check this box ☐ as I am not currently licensed.

Name of Trade or Profession	License Number	Granted by (licensing agency)	City or State issued
Specialty	Date License first issued	Registered From: (Month/Year)	Registered To: (Month/Year)

12. **DRIVER'S LICENSES:** If required on the announcement, do you have a valid license to operate a motor vehicle in New York State? ☐ Yes ☐ No If YES, we will need a copy with the application.

If you have a commercial motor vehicle driver's license, check the endorsements which you have.

☐ Hazardous Material ☐ Tank ☐ Other, please describe: _____

13. **DESCRIPTION OF EXPERIENCE:** Beginning with the most recent, describe below all employment which is relevant to the Minimum Qualifications of the position for which you are applying. **All blanks must be completed fully.** Omissions will ***not*** be interpreted in your favor. Information must be on the application. **Do not use a resume to supplement.**

LENGTH OF EMPLOYMENT From: **To:**	**FIRM NAME**	**ADDRESS**	**CITY and STATE**
EARNINGS (circle one) **$ /WK/MO/YR**	**PERCENT OF TIME**	**DUTIES PERFORMED**	
TYPE OF BUSINESS			
YOUR TITLE			
NAME OF YOUR SUPERVISOR			
SUPERVISOR'S TITLE			
Number of hours worked per week (exclusive of overtime)			

DO NOT ATTACH A RESUME

NAME: ____ Title of position: ____

ADDITIONAL DESCRIPTION OF EXPERIENCE

LENGTH OF EMPLOYMENT From: To:	FIRM NAME	ADDRESS	CITY and STATE
EARNINGS (circle one) $ /WK/MO/YR	PERCENT OF TIME	DUTIES PERFORMED	
TYPE OF BUSINESS			
YOUR TITLE			
NAME OF YOUR SUPERVISOR			
SUPERVISOR'S TITLE			
Number of hours worked per week (exclusive of overtime)			

LENGTH OF EMPLOYMENT From: To:	FIRM NAME	ADDRESS	CITY and STATE
EARNINGS (circle one) $ /WK/MO/YR	PERCENT OF TIME	DUTIES PERFORMED	
TYPE OF BUSINESS			
YOUR TITLE			
NAME OF YOUR SUPERVISOR			
SUPERVISOR'S TITLE			
Number of hours worked per week (exclusive of overtime)			

LENGTH OF EMPLOYMENT From: To:	FIRM NAME	ADDRESS	CITY and STATE
EARNINGS (circle one) $ /WK/MO/YR	PERCENT OF TIME	DUTIES PERFORMED	
TYPE OF BUSINESS			
YOUR TITLE			
NAME OF YOUR SUPERVISOR			
SUPERVISOR'S TITLE			
Number of hours worked per week (exclusive of overtime)			

DUPLICATE THIS PAGE IF ADDITIONAL DESCRIPTION OF EXPERIENCE IS NEEDED

NAME: _____ Title of position: _____

ADDITIONAL DESCRIPTION OF EXPERIENCE

LENGTH OF EMPLOYMENT **From:** **To:**	**FIRM NAME**	**ADDRESS**	**CITY and STATE**
EARNINGS (circle one) **$ /WK/MO/YR**	**PERCENT OF TIME**	**DUTIES PERFORMED**	
TYPE OF BUSINESS			
YOUR TITLE			
NAME OF YOUR SUPERVISOR			
SUPERVISOR'S TITLE			
Number of hours worked per week (exclusive of overtime)			

CONSUMER REPORT DISCLOSURE STATEMENT

In compliance with the Fair Credit Reporting Act (Public Law 91-508), you are notified that in connection with and in order to better evaluate this application for employment, a report may be obtained which will provide applicable information concerning character, general reputation and personal characteristics including, but not limited to, verification of prior employment, verification with the Department of Motor Vehicles, and a character check, including verification and review of any criminal convictions. You have the right to make a written request with a reasonable period of time for a complete and accurate disclosure of the nature and scope of the report requested.

I hereby authorize Orleans County to procure a consumer report as set forth above.

_____ _____

Signature of Applicant Date

After a conditional offer of employment had been made, you may be required to submit to a medical examination and you will complete a self-evaluation health form, prior to reporting to work.

New York State Human Rights Law and Federal Equal Employment Opportunity Law prohibit discrimination. Orleans County is an equal opportunity employer and does not discriminate on the basis of race, creed, color, national origin, sex, marital status, age, disability, veteran's status, arrest record, or any other status protected by law.

County of Orleans
Department of Personnel and Self Insurance

JOHN C. WELCH, JR.
Director

14016 Route 31 West
Albion, NY 14411-9354
(585) 589-3108
Fax (585) 589-3183
jwelch@orleansny.com

INFORMED CONSENT AND RELEASE OF LIABILITY FOR DRUG TESTING AND/OR ALCOHOL TESTING

In compliance with Orleans County Drug/Alcohol Policy, I hereby give my voluntary consent for a urine sample and/or saliva sample to be collected from me for chemical analysis. I understand the purpose of this analysis is to determine the presence or absence of **alcohol and/or unlawful drugs** in my body. I also understand that any positive result or refusal to take or cooperate with the test will preclude my employment with the County.

I further consent to the release of the results to Orleans County Personnel for use in evaluating my potential employment with the County. I understand that a chain of custody exists to insure the identity and integrity of my specimen and that information with respect to this test will be kept confidential, except to the extent required by the County to evaluate my employment. I further agree to hold Orleans County harmless for the use and results of this test, and to release Orleans County from any liability or claims arising from this test.

I state that the following sets forth all prescription and non-prescription medications I am taking at this time of this test:

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1. AT THE TIME OF APPLICATION – THIS FORM NEEDS TO BE SIGNED AND DATED BY THE APPLICANT SO YOU ARE AWARE OF DRUG TESTING.
2. WHEN OFFERED AN APPOINTMENT TO A POSITION, APPLICANT WILL COME TO PERSONNEL OFFICE TO PICK UP THIS FORM TO BE TAKEN TO THE PHYSICIAN'S OFFICE FOR TESTING.

_____ **X**_____
Authorizing Witness Applicant/Employee Signature

_____ **X**_____
Date Date

The above patient has been seen and the information has been reviewed.

_____ _____
Physician Signature Date

3/21/01- 8/2/02

County of Orleans
Department of Personnel and Self Insurance

JOHN C. WELCH, JR.
Director

14016 Route 31 West
Albion, NY 14411-9354
(585) 589-3108
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TO: **Applicants for County Employment**

PLEASE RESPOND TO THE FOLLOWING QUESTION

Does a relative or a relative member of the applicant's household exist between you and any County Official, whether appointed or elected or employee of the Orleans County?

Relative: Includes individuals who are relative by blood, marriage or adoption including the following: parent, child, spouse, brother, sister, grandparent, aunt, uncle, niece, nephew, grandchild, legal guardian, foster child, in-laws and step relationships.
Relative member of the applicant's household: Includes individuals who are cohabiting with the employee as well as any individual of the cohabitant who are relative by blood, marriage or adoption including the following: parent, child, spouse, brother, sister, grandparent, aunt, uncle, niece, nephew, grandchild, legal guardian, foster child, in-laws and step relationships.

Yes: _____ No: _____

If yes (please identify) the County Official or employee

_____ _____
County Official or employee title

_____ _____
Department (if known) relationship to the individual

I affirm that this is an addendum to my employment application and is true under penalties of perjury.

_____ _____ _____
Print Name of Applicant Signature of Applicant Date

Applicant's Name: _____

REFERENCES

Complete the following information concerning persons who may attest to your character, integrity and fitness for the position for which you are applying. List four (4) personal and three (3) employment references (employers, supervisors or co-workers). **Do Not** include relatives as personal references.

Personal:

A. Name _____ Phone # _____

Address _____
Street City State Zip Code

Relationship _____ Years Known _____

B. Name _____ Phone # _____

Address _____
Street City State Zip Code

Relationship _____ Years Known _____

C. Name _____ Phone # _____

Address _____
Street City State Zip Code

Relationship _____ Years Known _____

D. Name _____ Phone # _____

Address _____
Street City State Zip Code

Relationship _____ Years Known _____

Applicant's Name: _____

Employment:

E. Name _____ Phone # _____

Address _____
Street City State Zip Code

Relationship _____ Years Known _____

Business _____ Phone # _____

Address _____
Street City State Zip Code

F. Name _____ Phone # _____

Address _____
Street City State Zip Code

Relationship _____ Years Known _____

Business _____ Phone # _____

Address _____
Street City State Zip Code

G. Name _____ Phone # _____

Address _____
Street City State Zip Code

Relationship _____ Years Known _____

Business _____ Phone # _____

Address _____
Street City State Zip Code

AUTHORIZATION FOR SEARCH AND EXCHANGE OF INFORMATION

Criminal History Records Checks
(Certain Health Care Workers)

I, _____, hereby
(Name of applicant for employment)

Authorize (Check all of the following operators to which you have made an application for employment)

_____ The Villages of Orleans Health & Rehabilitation Center

_____ Orleans County Public Health Department

To submit a request to the Attorney General of the United States to conduct a search of the records of the Criminal Justice Information Services Division of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints of other identification information submitted by me. I further authorize the exchange of such information between the Attorney General of the United States, the New York State Department of Health and the operator(s) indicated above. This information may be used only by the specified operator(s) and only for the purpose of determining my suitability for employment in a position involved in direct patient care.

_____ _____

Name (Print) Signature

_____

Date

REVIEW NOTICE REGARDING CRIMINAL HISTORY RECORD CHECKS ON THE REVERSE SIDE OF THIS FORM AND SIGN ACKNOWLEDGEMENT

10/01/2008

NOTICE REGARDING CRIMINAL HISTORY RECORD CHECKS

Required by NYS Department of Health

You have applied for employment in an unlicensed position involving the direct care and/or supervision of patients in The Villages of Orleans Health & Rehabilitation Center or the Orleans County Department of Public Health (the "operator"). Under New York State Law, the operator must conduct a criminal history record check on you. The process for the criminal history record check is as follows:

- You complete: (1) an Orleans County Application for Examination or Employment, (2) a signed sworn statement regarding your criminal convictions and findings of patient or resident abuse on a form provided by the County, and (3) an Authorization for Search and Exchange of Information form. You provide the completed documents to the Orleans County Personnel Office.
- If your application is approved, your application documents (listed in prior bulleted item) will be forwarded to the operator. If the operator makes a conditional offer of employment to you, you must be fingerprinted. The operator will give you an instruction sheet and fingerprint card to take to the Orleans County Sheriff's Office (Jail) for fingerprinting.
- You must return the fingerprint card to the Personnel Office. The Personnel Office will forward your fingerprint card to the operator.
- The operator will forward the fingerprint card, and any other required information and fees to the New York State Department of Health ("NYSDOH"). (You are *not* responsible for the payment of any fees associated with the criminal history record check.
- The NYSDOH will submit these items to the United States Attorney General ("USAG") for a full search of the records of the Federal Bureau of Investigation.
- The USAG will provide the requested information to the NYSDOH.
- The NYSDOH will forward this information to the operator.
- The operator will review the information to determine whether there are any criminal convictions that may disqualify you from employment. If so, the operator will provide you with an opportunity to obtain, review and explain any criminal history record information contained in the criminal history record check.
- If the operator disqualifies you on the basis of a criminal conviction, it will put the basis of this decision in writing.

YOU HAVE THE RIGHT TO WITHDRAW YOUR APPLICATION FOR EMPLOYMENT AT ANY TIME, WITHOUT PREJUDICE, PRIOR TO THE OPERATOR'S DECISION ON EMPLOYMENT. YOUR REQUEST TO WITHDRAW YOUR APPLICATION SHOULD BE MADE IN WRITING AND DELIVERED TO THE ORLEANS COUNTY PERSONNEL OFFICE. UPON A WITHDRAWAL, YOUR FINGERPRINTS AND CRIMINAL HISTORY RECORD WILL BE DESTROYED.

I acknowledge receipt of a copy of this notice.

_____ _____

Name (Print) **Signature**

Date:_____

10/1/2008

SWORN STATEMENT REGARDING
FINDINGS OF PATIENT / RESIDENT ABUSE
AND CONVICTIONS FOR CRIMES AND VIOLATIONS

I, _____, am providing the following information in connection
(Print Name)
with my Orleans County Application for Examination or Employment.

Section 1: Findings of Patient / Resident Abuse

Have you ever been found guilty of patient or resident abuse? ☐ Yes ☐ No

If no, proceed to Section 2.

If yes, complete the following:

[If you were found guilty of more than one (1) instance of patient resident abuse, request an additional page for each additional incident.]

Date of incident for which you were found guilty of patient / resident abuse	
Full description of the act(s) of patient / resident abuse	
Name of your employer at time of incident	
Your job title	
Action taken by your employer toward you as a result of the incident	
Identify any State or Federal agency that investigated the incident	
Findings of State or Federal agency	
Action taken by the State or Federal agency	

Attach an additional sheet if more space is needed.

CONTINUED TO NEXT PAGE.

Section 2: Convictions

Have you ever been convicted of a felony, misdemeanor or violation? ☐ Yes ☐ No

If no, proceed to Section 3.

If yes, complete the following:

[If you have more than one conviction, request an additional page for each additional conviction.]

Name of criminal offense	
Date of the offense	
Date of the conviction	
Classification of the offense	☐ **Felony, Class _____** ☐ **Misdemeanor, Class _____** ☐ **Violation**
Name of Court	
Location of court (municipality & state)	
What happened? (Describe fully the events that were the basis of the criminal offense.)	
Sentence imposed	
Sentence completed to date	
What was your age at the time of the offense?	
Specify any evidence you have of rehabilitation	
Do you have a certificate of relief from disabilities or a certificate of good conduct?	☐ **Yes (provide a copy)** ☐ **No**

Attach an additional sheet if more space is needed.

Section 3: Affirmation

I swear or affirm that the information contained herein, including any information submitted on additional sheets, is true and correct.

_____ _____

Date Signature of Applicant

NOTARY ACKNOWLEDGEMENT

INSTRUCTIONS TO NOTORY: The applicant must sign this document under oath or affirmation. You must administer this oath by asking the applicant, "Do you solemnly, sincerely and truly declare and affirm that the statements made by you in this Sworn Statement Regarding Findings of Patient / Resident Abuse and Convictions for Crimes and Violations and its attachments are true and correct?" The applicant should state, "yes" or "I do". After the applicant has replied in the affirmative you must complete the following.

Sworn to before me this _____ day of _____, 20____.

_____

NOTARY PUBLIC (Please sign & affix stamp)

Section 1 Response Continued

Name: _____
[Print]

It is my intent that the information provided on this sheet be considered part of the response to my Sworn Statement Regarding Findings of Patient Resident Abuse and Convictions for Crimes and Violations, and that I am providing this information under the Affirmation included in Section 3 of that form.

Date of incident for which you were found guilty of patient / resident abuse	
Full description of the act(s) of patient / resident abuse	
Name of your employer at time of incident	
Your job title	
Action taken by your employer toward you as a result of the incident	
Identify any State or Federal agency that investigated the incident	
Findings of State or Federal agency	
Action taken by the State or Federal agency	

Attach an additional sheet if more space is needed.

Section 2 Response Continued

Name: _____
[Print]

It is my intent that the information provided on this sheet be considered part of the response to my Sworn Statement Regarding Findings of Patient Resident Abuse and Convictions for Crimes and Violations, and that I am providing this information under the Affirmation included in Section 3 of that form.

Name of criminal offense	
Date of the offense	
Date of the conviction	
Classification of the offense	☐ **Felony, Class _____** ☐ **Misdemeanor, Class _____** ☐ **Violation**
Name of Court	
Location of court (municipality & state)	
What happened? (Describe fully the events that were the basis of the criminal offense.)	
Sentence imposed	
Sentence completed to date	
What was your age at the time of the offense?	
Specify any evidence you have of rehabilitation	
Do you have a certificate of relief from disabilities or a certificate of good conduct?	☐ **Yes (provide a copy)** ☐ **No**

Attach an additional sheet if more space is needed.