

REQUIRED MEDICAL INFORMATION: Please attach a copy of TB Mantoux testing results done with the current year.

What hobbies, skills, special interests, training, and/or related experience would you like to utilize as a REHAB Programs, Inc. volunteer?

Community Affiliations/Volunteer History (clubs, social groups, other organizations)_____

CHARACTER REFERENCES

Please list the names and addresses of 3 persons who would be willing to respond to a reference letter for you.

Is there additional information you would care to share with us which would pertain to your application for a volunteer assignment at REHAB Programs, Inc.?

STATEMENT OF APPLICATION

The above statements are true and all information and reference given on this application may be investigated without liability of REHAB Programs, Inc. If accepted to participate in the Student program I agree to abide by the policies of REHAB Programs, Inc. I understand that any of the statements in this application are found to be untrue, or I fail to comply with all stated requirements, I may be subject to immediate dismissal from the Rehab Volunteer Program.

Signature_____

Date_____

HUMAN RESOURCES INFORMATION

To be completed by Program Supervisor:

Starting Date:_____

Orientation Schedule:_____

Signature Program Director

Date

DRIVERS LICENSE STATEMENT

Applicants for employment whose job will involve driving are required to provide a statement indicating convictions related to moving violations, as well as any incident involving harm to person or property while driving.

1. I have a valid N.Y. State driver's license. YES _____ NO _____
2. Has my license to drive in N.Y. State ever been suspended, or revoked YES _____ NO _____

PLEASE PROVIDE DETAILS: _____

DATE OF SUSPENSION OR REVOCATION: _____ / _____ / _____ COURT: _____

3. I was involved in a traffic incident that led to harm to persons, or property while driving within the last 3 years.
YES _____ NO _____

PLEASE PROVIDE DETAILS: _____

DATE AND DESCRIPTION OF INCIDENT: _____

4. I have been convicted of a moving traffic violation during the last 3 years. YES _____ NO _____

PLEASE PROVIDE DETAILS: _____

DATE OF VIOLATION _____ / _____ / _____ COURT: _____

SIGNATURE: _____ DATE: _____ / _____ / _____

****CONVICTIONS WILL NOT NECESSARILY DISQUALIFY APPLICANT FROM EMPLOYMENT****

REHAB Programs, Inc.
70 Overocker Road
Poughkeepsie, NY 12603

RELEASE AUTHORIZATION

I hereby authorize past employers, professional acquaintances, and friends to release unto REHAB Programs, Inc. or its agents thereof, any information related to my employment history with said company, including but not limited to, dates of employment, attendance, performance, conduct/discipline, capabilities and other qualities related to my qualifications for employment. I further release the said company(s) and/or agents from any claims that may arise for providing such information.

Signature _____

Date _____

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Signature _____

Date _____

**PRE-EMPLOYMENT
CONTAGIOUS DISEASE STATEMENT**

Volunteer/Intern Applicants with REHAB Programs Inc., are herewith notified that the agency is required to admit program participants into each of its programs, without regard to their health status. Therefore, it is possible that a Volunteer/Intern of this agency will, during the course of their internship, be exposed to program participants who are infected with contagious diseases. This notice serves to make you aware of this possibility. Additionally, if you are a volunteer/intern by this Agency you will be trained on methods of protecting yourself and others from contagious diseases.

I have read the above and understand that this statement will be reviewed further upon hire.

APPLICANT _____ DATE _____

APPLICANT DATA RECORD

Applicants are considered for all positions, and employees are treated during employment without regard to race, color, religion, sex, national origin, age, marital or veteran status, medical condition or disability.

As employers/government contractors, we comply with government regulations and affirmative action responsibilities.

Solely to help us comply with government record keeping, reporting and other legal requirements, please fill out the Applicant Data Record. We appreciate your cooperation.

This data is for periodic government reporting and will be kept in a *Confidential File* separate from the Application for Employment.

(PLEASE PRINT)

Date _____

Position(s) Applied For _____

Referral Source: Advertisement Friend Relative Walk-In School
 Employment Agency Other _____

Name _____ Phone (____) _____
LAST FIRST MIDDLE Area Code

Address _____
NUMBER STREET CITY STATE ZIP CODE

AFFIRMATIVE ACTION SURVEY

Government agencies require periodic reports on the sex, ethnicity, disability and veteran status of applicants. This data is for analysis and affirmative action only. Submission of information is voluntary.

Check one: Male Female

Check one of the following:
Race/Ethnic Group: White Black Hispanic
 American Indian/Alaskan Native Asian/Pacific Islander

Check if any of the following are applicable:
 Vietnam Era Veteran Disabled Veteran Disabled Individual

TO: All Staff, Job Applicants, Interested Parties

FROM: Human Resources Dept.

RE: Equal Employment Opportunity/Affirmative Action Policy

The Agency wishes to reaffirm that it will comply with federal, state and local anti-discrimination laws and rules as they relate to employment with this Agency. Specifically, we will not discriminate on the basis of race, color, creed, sex, disability, religion, age, marital or health status (to include those with known or suspected HIV (AIDS status) or sexual orientation. We will not tolerate sexual harassment of employees.

With the exception of those positions for which there exists **bona fide occupational qualification** permitting use of an otherwise prohibited factor, this agency will not take any of those factors into consideration with regard to recruitment, hiring, promotion, transfer, disciplinary procedures, separations and other terms and conditions of employment. Additionally, the Agency will take affirmative action to recruit, hire and advance through promotion minority persons, the disabled and veterans.

This endeavor, and its goal of achieving and maintaining equal employment opportunity for all persons, is of the highest priority for this organization, and the community, and has the full and positive support of the management of this organization.

March 16, 1978/Revised April 1, 1990

Employment Experience

Start with your present or last job. Include military service assignments and volunteer activities. Exclude organization names which indicate race, color, religion, sex or national origin.

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

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

Special Skills and Qualifications

Summarize special skills and qualifications acquired from employment or other experience _____

EDUCATION

	Elementary					High				College/University				Graduate/ Professional			
School Name																	
Years Completed (Circle)	4	5	6	7	8	9	10	11	12	1	2	3	4	1	2	3	4
Diploma Degree																	
Describe Course Of Study																	
Describe Specialized Training, Apprenticeship, Skills, and Extra-Curricular Activities																	

Honors Received:

State any additional information you feel may be helpful to us in considering your application.

CONDITIONS OF EMPLOYMENT (Please read carefully)

- I hereby declare that I am capable of performing the essential duties required of this position and understand that reasonable efforts will be made to accommodate restrictions in compliance with standards governing civil rights.
- If I am offered an internship/volunteer opportunity, I agree to submit to a medical examination and drug test before starting work. If employed, I also agree to submit to a medical examination or drug test at any time deemed appropriate by REHAB Programs Inc. and as permitted by law and the applicable (if any) collective bargaining agreement. I consent to such examinations and tests, and I request that the examining doctor disclose to REHAB Programs Inc. the results of the examination, which results shall remain confidential and segregated from my personnel file. I understand that my employment or continued employment, to the extent permitted by law, is contingent upon satisfactory medical examinations and drug tests, and if I am hired a condition of my employment will be that I abide by the Agency's drug and alcohol policy.
- If employed, I agree to protect the privacy of the participants Protected Health Information (PHI) and not to disclose such confidential information to others.
- I hereby authorize REHAB Programs Inc. or its Agent thereof, to make any inquires into my past criminal history record, if any, that reasonably relate to fitness to perform a particular job or bondability.

Signature of Applicant

Date

For Personnel Department Use Only

Arrange Interview Yes No

Remarks _____

Employed Yes No Date of Employment _____

Job Title _____ Hourly Rate/ Salary _____ Department _____

By _____ INTERVIEWER _____ DATE _____
NAME AND TITLE



CONFIDENTIALITY STATEMENT FOR VOLUNTEERS/INTERNS

70 OVEROCKER ROAD
POUGHKEEPSIE, NEW YORK 12603
TEL: 845-485-9803
FAX: 845-473-1270

As a volunteer at Rehab Programs, Inc., I understand that I may be privy to or have access to confidential information regarding clients/consumers, agency proprietary information, or agency operations. By signing below, I agree not to disclose any of this information to anyone outside the agency or to individuals within the agency (who may not be in a need to know position). This obligation to maintain confidentiality extends beyond separation from the agency.

Specifically, I understand that under HIPAA (Health Insurance Portability and Accountability Act), I am obligated to adhere to the following restrictions:

- Information from individual consumer files must not be copied or divulged to anyone.
- Information gained during the course of conversations regarding individual consumers must not be divulged to anyone.
- Discussions regarding confidential information must be kept to a minimum and in a secure location where such discussions cannot be overheard by others not in a need to know position.
- Information gained while working among confidential information (or within earshot of others conversations) must be kept confidential.
- Confidential information may not be used for any purpose other than agency business.
- Confidential information may not be used for personal gain.
- Only authorized staff have access to files.
- Files are to be locked when authorized staff are not present.
- Offices containing confidential information must be shut (and locked if necessary) when authorized staff are not present.
- Individual computers must be secured and not accessible by others.
- Individual passwords must not be shared.
- Computer screens must not face the door unless there is a scrambler on the screen.

Further, I understand that it is the responsibility of each and every one of us to ensure the privacy and confidentiality of consumers and their files and will report any violations that I observe.

NAME

DATE

*Approved by HIPAA Subcommittee on 10/16/02.



Criminal History Record Check Consent Form

NYS Office of Mental Retardation and Developmental Disabilities
 Criminal Background Check Unit
 PO Box 3005
 Schenectady, NY 12303-0005
 cbc.unit@omr.state.ny.us

The purpose of this form is to verify that the applicant understands and consents to the criminal history record check process.

Instructions:

1. Applicant must complete all fields on this form. Please print legibly.
2. Submit to Agency/Registered Provider/DDSO to retain.

Last Name		First Name	MI
Date of Birth		Social Security Number	
Street Address or PO Box (applicant's)			
City	State	Zip	

PLEASE READ EACH STATEMENT BEFORE SIGNING

By signing this consent form I am acknowledging that I understand and consent to the following statements:

1. I understand that _____ (agency/DDSO/registered provider) is required/authorized by New York State Mental Hygiene Law 31.35 and Executive Law 845-b to request a check of my criminal history record.
2. Criminal history record checks are requested from the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI). The OMRDD CBC Unit is authorized to receive the results of the criminal history record check and to develop a summary of the results. The summary will indicate:
 - whether I have a criminal history record, as maintained by DCJS and/or the FBI;
 - specific crimes for which I was convicted (felony or misdemeanor) or criminal charges which do not reflect a disposition;
 - the date of the criminal charge or conviction; and
 - the jurisdiction in which the charge or conviction took place.
3. I hereby consent to the OMRDD CBC Unit providing the summary of my criminal history record information, which includes information from both DCJS and the FBI, to the agency/DDSO listed above.
4. If I am an applicant for employment, I may withdraw my request without prejudice at any time before my application is accepted or declined regardless of whether my criminal history record information has been reviewed.
5. I have been informed that I have the right to obtain, review and seek correction of my criminal history record information under regulations and procedures established by the New York State Division of Criminal Justice Services and the Federal Bureau of Investigation.
6. I have been informed of the reason for the request for my criminal history record information and consent to having my fingerprints taken for the purpose of a criminal history record check by the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).

Signature _____ Date _____

Signature _____ Date _____

(of parent or legal guardian if applicant is under 18 years)

