THE GRAND HEALTHCARE SYSTEM

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70 E SUNRISE HWY STE. 605 – VALLEY STREAM, NEW YORK 11581 – (718) 215-6000

PRE-EMPLOYMENT APPLICATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	

STREET ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	MOBILE PHONE	EMAIL ADDRESS
___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___	___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___	

POSITION DESIRED	AVAILABILITY (select all that apply)
	☐ DAY ☐ EVENING ☐ NIGHT ☐ FULL-TIME ☐ PART-TIME ☐ PER DIEM AVAILABLE START DATE: _____

EDUCATION

SCHOOL	NAME & LOCATION	COURSE OF STUDY	NUMBER OF YEARS COMPLETED	DID YOU GRADUATE?	DEGREE OR DIPLOMA
HIGH SCHOOL					
COLLEGE					
GRADUATE					
SPECIALIZED TRAINING, ETC.					

PLEASE ANSWER THE FOLLOWING QUESTIONS	YES	NO
Are you at least 16 years of age?		
If you are under 18 years of age, can you provide proof of your eligibility to work?		
Are you legally eligible for employment in the United States? (proof of citizenship/ immigration status is required upon employment)		
Have you ever applied for a position with a Grand facility (including this facility) or any of its affiliates? If yes, when (date)? _____		
Have you ever been employed with a Grand facility (including this facility) or any of its affiliates? If yes, which facility? _____		
Have you ever held a license, registration, certification or another credential under another name? If yes, please give name: _____		

How did you hear about our company? _____

If you were referred by a friend or family member, please give name: _____

Do you have any relatives working for The Grand? (This information is only used to avoid conflicts of interest arising from supervisor/ employee relationships involving relatives.) ☐ YES ☐ NO

If yes, complete the following:

RELATIVE NAME: _____ *RELATIONSHIP:* _____ *DEPARTMENT:* _____

PREVIOUS EXPERIENCE

Please provide the following information, starting with your most recent employer.

DATES EMPLOYED	COMPANY NAME	ADDRESS & PHONE NUMBER	ROLE/ TITLE

Tasks performed: _____

_____

Reason for leaving: _____

DATES EMPLOYED	COMPANY NAME	ADDRESS & PHONE NUMBER	ROLE/ TITLE

Tasks performed: _____

_____

Reason for leaving: _____

DATES EMPLOYED	COMPANY NAME	ADDRESS & PHONE NUMBER	ROLE/ TITLE

Tasks performed: _____

_____

Reason for leaving: _____

REGISTERED, LICENSED OR CERTIFIED APPLICANTS ONLY

Are you currently registered, licensed or certified as a health care giver in New York state? ☐ *YES* ☐ *NO*

If yes, License/ Certificate Number _____ *Expiration Date:* _____

Are you registered in another state? ☐ *YES* ☐ *NO* *If yes, State* _____ *License #* _____

Has your license ever been suspended or revoked or are you currently involved in any proceeding that could affect your license or certification? ☐ *YES* ☐ *NO*

REFERENCES

Please provide the names and telephone numbers of three references who are not related to you that we may contact.

NAME	RELATIONSHIP	PHONE

SKILLS & QUALIFICATIONS

Please provide any additional information you feel necessary to describe your full qualifications (i.e. specialty areas, skills, etc.).

_____

_____

Do you speak, read or write in any language other than English? ☐ YES ☐ NO If yes, what language(s): _____

I CERTIFY THAT THE FACTS IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IF EMPLOYED, FALSIFIED STATEMENTS ON THIS APPLICATION WILL BE GROUNDS FOR DISMISSAL. I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED HEREIN AND THE REFERENCES LISTED ABOVE TO GIVE YOU ANY AND ALL INFORMATION CONCERNING MY PREVIOUS EMPLOYMENT AND ANY PERTINENT INFORMATION THEY MAY HAVE, AND RELEASE ALL PARTIES FROM ALL LIABILITY. I UNDERSTAND AND AGREE THAT, IF HIRED, MY EMPLOYMENT IS FOR NO DEFINITE PERIOD AND MAY BE TERMINATED AT ANY TIME WITHOUT PRIOR NOTICE AND WITHOUT CAUSE.

SIGNATURE: _____ **DATE:** _____