Community Inclusion, Inc.

EMPLOYMENT APPLICATION

---

1. Applicant Information

Full Legal Name: _____
Other Names Used (if any): _____

Address:
Street: _____
City: _____ State: NY Zip: _____

Phone Number: _____
Email Address: _____

Are you legally authorized to work in the United States?
☐ Yes ☐ No

Are you at least 18 years of age?
☐ Yes ☐ No

---

2. Position Applied For

Position Title: _____
Department: _____
Employment Type:
☐ Full-Time ☐ Part-Time ☐ Per Diem ☐ Temporary

Shift(s) Available:
☐ Days ☐ Evenings ☐ Nights ☐ Weekends

Date Available to Start: _____

---

3. Professional Licensure / Certification (If Applicable)

License/Certification Type: _____
License Number: _____
State Issued: _____
Expiration Date: _____

☐ I certify that my license/certification is current and in good standing.

4. Education

High School: _____
Did you graduate? ☐ Yes ☐ No

College / University / Training Program:
Name: _____
Degree/Certificate Earned: _____
Dates Attended: _____

5. Employment History

(List most recent first)

Employer #1
Name: _____
Address: _____
Position Held: _____
Dates of Employment: From _____ To _____
Supervisor Name & Phone: _____
Reason for Leaving: _____

Employer #2
Name: _____
Position Held: _____
Dates of Employment: From _____ To _____

6. Health Care–Specific Questions

Have you ever been **excluded from participation** in Medicare, Medicaid, or any federal or state health care program?
☐ Yes ☐ No

Have you ever been **disciplined, suspended, or terminated** from a health care position?
☐ Yes ☐ No
If yes, please explain: _____

Are you willing to comply with required **background checks, drug screening, TB testing, immunizations, and physical exams** as required by NYS and facility policy?
☐ Yes ☐ No

7. Criminal History Statement

(In accordance with New York State law, a criminal conviction does not automatically disqualify employment.)

Have you ever been convicted of a crime (excluding sealed or expunged records)?
☐ Yes ☐ No
If yes, please explain: _____

---

8. References

(Professional references preferred)

Reference #1
Name: _____ Relationship: _____
Phone/Email: _____

Reference #2
Name: _____ Relationship: _____
Phone/Email: _____

---

9. Applicant Statement & Authorization

Please read carefully before signing:

I certify that the information provided in this application is true and complete to the best of my knowledge. I understand that false or misleading information may result in disqualification or termination of employment.

I authorize the employer to investigate my employment history, credentials, and references, and to conduct background checks as permitted by New York State and federal law.

I understand that employment, if offered, is **at-will**, meaning either the employer or I may terminate employment at any time, with or without cause or notice, unless otherwise required by law or contract.

Applicant Signature: _____
Date: _____

---

10. Equal Employment Opportunity Statement

This facility is an Equal Opportunity Employer and does not discriminate based on race, color, religion, sex, gender identity, sexual orientation, national origin, age, disability, marital status, veteran status, or any other status protected by New York State or federal law.

NYS DOH A-28 Personnel Background Disclosure & Attestation

Disclosure Statement

In accordance with **New York State Department of Health A-28 guidance**, all individuals who have, or may have, **direct or indirect contact with patients or residents, access to patient information, or access to the physical plant** of the facility are required to disclose the following information as a **condition of employment or engagement**.

Criminal Conviction Disclosure

Have you ever been convicted of a **felony or misdemeanor** in New York State or any other jurisdiction?
(Do not include arrests that did not result in conviction, or records that have been sealed or expunged pursuant to law.)
☐ Yes ☐ No

If yes, provide the **nature of the offense, date, and disposition**:

Disclosure of a conviction does not automatically disqualify an applicant from employment. All disclosures are reviewed in accordance with Article 23-A of the New York State Correction Law.

Medicaid / Medicare Exclusion Attestation

I attest that I am **not currently excluded, suspended, or otherwise ineligible** to participate in **Medicaid, Medicare, or any other federal or state health care program**, including exclusion by the **Office of Inspector General (OIG)**.

☐ Yes ☐ No

If no, explain:

Prior Employment Disclosure

Have you ever been **terminated, involuntarily separated, or subject to disciplinary action** related to patient care, resident safety, abuse, neglect, mistreatment, misappropriation of property, or falsification of records at any **DOH-licensed or certified facility**?
☐ Yes ☐ No

If yes, explain fully:

A-28 Authorization & Acknowledgment

I acknowledge and understand that, in compliance with **NYS DOH A-28 requirements**, this facility is required to:

- Conduct and document a **criminal history background review**
- Verify my status against **state and federal exclusion lists**
- Verify **employment history, licensure, and credentials**
- Maintain documentation demonstrating **A-28 compliance** for DOH survey and audit purposes

I further understand that **failure to disclose required information**, or submission of **false, misleading, or incomplete information**, may result in **withdrawal of an employment offer, disciplinary action, or termination**, and may be reportable to regulatory authorities.

Applicant Attestation

I hereby attest that the information provided is **true, accurate, and complete** to the best of my knowledge. I understand that **A-28 compliance is a condition of employment** and that this disclosure may be subject to **review by the New York State Department of Health**.

Applicant Name (Printed): _____
Applicant Signature: _____
Date: _____

Facility Determination (Required for Audit Trail)

☐ Reviewed in accordance with A-28
☐ Exclusion lists checked and cleared
☐ Applicant approved for hire
☐ Applicant not approved (document rationale)

Reviewer Name & Title: _____
Signature: _____ Date: _____
