empro STAFFING
The Employment Professionals

APPLICATION FOR EMPLOYMENT

What position are you applying for _____ Type of Work: ☐ Full time ☐ Part time ☐ On call

PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____ Date of Birth _____

Mailing Address _____ Apt/Floor _____ City _____ State _____ Zip Code _____

Email Address _____ Mobile Number _____ Social Security # _____

Birth Country _____ Emergency Contact Name: _____ Emergency Contact # _____

Have you ever been convicted of a crime, including misdemeanor? ☐ Yes ☐ No If yes, please describe the crime and when it took place _____

_____

Do you have a final finding of patient or resident abuse? ☐ Yes ☐ No

What is your citizenship or immigration status? ☐ U.S. Citizen ☐ Permanent Resident ☐ Work Authorization

Where did you hear about us? ☐ Indeed ☐ ZipRecruiter ☐ MyCNAJobs ☐ LinkedIn ☐ Google ☐ Word-of-Mouth ☐ Referral _____

AVAILABILITY

Please indicate with a check √ the times you are available to work. This gives our client facilities an idea of your availability and the shifts that may, or may not, work with your schedule.

	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Morning							
Evening							
Overnight							

Note*: All staff, regardless of the type of work, are required to work **EVERY OTHER** Saturday and Sunday unless stated otherwise. By proceeding with this application, you acknowledge and agree to work every other weekend (both Saturday and Sunday; no exception). Please indicate above with a check √ the shift(s) you are available to work on the weekend.

EMPLOYMENT HISTORY

Employer	Location	Phone #	Supervisor Name	Dates of Employment From (mm/yyyy)	To (mm/yyyy)

I ☐ **give permission** ☐ **do not give permission** for you to contact my current employer for a reference.

EDUCATIONAL BACKGROUND

School/Program (begin with most recent school/program attended)	Degree/Certificate Earned	Year Graduated

I ☐ **give permission** ☐ **do not give permission** for you to contact my past educational institutions.

PROFESSIONAL REFERENCES

Please provide the name of three professional references (former employer, coworker, supervisor, etc.).

Professional Reference Name	Job Title	Where did you work together (company Name)?	Phone Number

I ☐ give permission ☐ do not give permission for you to contact my professional references.

PROFESSIONAL CONDUCT

We expect all employees to always conduct themselves with the utmost professionalism. It is required that employees follow the policies and procedures of each facility they are working in. Every employee is further responsible for accepting accountability and responsibility for their own actions. Employees must exercise informed judgment and use individual competency and qualifications when accepting responsibilities, duties, consultations, and delegating nursing activities to others.

DRESS CODE

Employees are required to wear the appropriate nursing uniforms or scrubs to all their assignments along with appropriate footwear. Clogs, slip-ons, or any type of sandals are unacceptable. Please be advised that dress code varies per nursing home. All staff must maintain a clean well-kept appearance with good hygiene. Nails must be kept clean and of a short, neat length. Please refrain from wearing excessive jewelry, make-up and / or perfumes.

ORIENTATION

Employees may be paid for their orientation after completing their classroom training and buddy up shifts. Orientation consists of 1–2 days classroom training and 3-5 days buddy up. If orientation is not completed, for any reason, no part of the orientation will be paid for. It is imperative that employees complete their orientation to be paid.

Employees are responsible for their own schedules. **Once you accept a shift or schedule you are obligated to fulfill that commitment.**

OVERTIME & HOLIDAY PAYMENT AGREEMENT

Overtime: Time-and-a-half is paid for hours worked over 40 hours in a week.
Holiday: Unless stated otherwise by the nursing home facility, if working on the holiday results in more than 40 hours worked that week, employee will **ONLY** be paid time-and-a-half for those extra hours NOT both (overtime and holiday). However, if the holiday hours exceed those extra overtime hours, then the employee will be paid time-and-a-half for the holiday hours. On rare occasions, a nursing home facility may pay both overtime and holiday hours worked in a week.

CANCELLATION & LATENESS

Dependability is expected and those employees who provide consistent, reliable service will be remembered, and the staffing coordinators will habitually contact you for scheduling. We do understand that extenuating circumstances do arise and a call-out may be unavoidable. If this should occur, it is your responsibility to contact the facility as soon as possible, and at least two hours before the start of the shift. **Lateness is unacceptable and will not be tolerated.** If you are running late, you must notify the facility. Persons with excessive lateness will be tracked and disciplinary action will be taken. Excessive lateness, cancellations or even one no-call no-show will result in disciplinary action, which may include termination.

PLEASE READ BEFORE SIGNING

My signature verifies that the information provided in this application is true and complete. I understand the agency is an Equal Opportunity Employer. I understand that falsification, including withholding of information, on this application is grounds for immediate dismissal if I am selected for a position. I further understand that if I am hired, I can be terminated, with or without cause and with or without notice. I agree to have my picture taken for identification purposes and to submit to fingerprinting and drug screening test upon request. I understand the agency has the right to run a criminal background check and may pass on the results upon request. I understand that the physical information that I provide to the agency may be released to any facility upon their request. I understand that all references listed above may be contacted in addition to past employers and educational institutions.

By signing this, I verify that I have read the above, had an opportunity to clarify information about items I did not understand and agree with the above parameters.

Applicant's Signature _____ Date _____

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Notice and Acknowledgement of Pay Rate and Payday
Under Section 195.1 of the New York State Labor Law
Notice for Hourly Rate Employees

1. Employer Information

Name: Empro Staffing

Doing Business As (DBA) Name(s):

FEIN (optional):

Physical Address: 1418 65th Street, Brooklyn, NY 11219

Mailing Address: 1418 65th Street, Brooklyn, NY 11219

Phone: (718) 435-6600

2. Notice given:
☒ At hiring
☐ Before a change in pay rate(s), allowances claimed or payday

3. Employee's rate of pay: $ _____ per hour

4. Allowances taken:
☒ None
☐ Tips _____ per hour
☐ Meals _____ per meal
☐ Lodging _____
☐ Other _____

5. Regular payday: Thursday

6. Pay is:
☒ Weekly
☐ Bi-weekly
☐ Other

7. Overtime Pay Rate: $_____ per hour (This must be at least 1½ times the worker's regular rate with few exceptions.)

8. Employee Acknowledgement:
On this day I have been notified of my pay rate, overtime rate (if eligible), allowances, and designated pay day on the date given below. I told my employer what my primary language is.

Check one:

☐ I have been given this pay notice in English because it is my primary language.

☐ My primary language is _____. I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

_____ _____
Print Employee Name Employee Signature

__/__/_____ _____
Date Preparer's Name & Title

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

Please note: It is unlawful for an employee to be paid less than an employee of the opposite sex for equal work. Employers also may not prohibit employees from discussing wages with their co-workers.

NEW YORK STATE DEPARTMENT OF HEALTH

Criminal History Record Check

NEW YORK STATE | Department of Health

DOH CHRC form 102: Acknowledgement and Consent for Fingerprinting and Disclosure of Criminal History Record Information

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

Last Name | First Name | Middle Initial | Maiden Name

Date of Birth (mm/dd/yyyy) | Alias/AKA | Mother's Maiden Name

Mailing Address (street) | City | State | ZIP Code

SECTION 2 – ATTESTATION

1.	I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).
2.	I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
3.	I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary. In accordance with applicable laws, DOH will furnish appropriate summary information to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law. I have been informed that upon receiving notification from DCJS that there is a subsequent pending criminal action or proceeding or conviction, the DOH shall promptly notify an authorized person(s) of a provider of the additional allegation or new conviction.
4.	I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.
5.	I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI. If I believe an error has been made by DCJS for any New York State conviction/charge or the FBI for a non-New York State conviction/charge, I understand that I should notify DCJS and/or the FBI to report and request correction of this error to the addresses below.
	NYS Division of Criminal Justice Services Criminal History Bureau Record Review Unit-5th Floor 4 Tower Place, Albany, NY 12203 (518) 485-7675 — Federal Bureau of Investigation Criminal Justice Information Services (CJIS) Division 1000 Custer Hollow Road, Clarksburg, WV 26306 (304) 625-5590
6.	I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.
7.	I certify to the best of my knowledge and belief that I (check as appropriate): ◯ Have ◯ Have not been convicted of a crime in New York State or any other jurisdiction ◯ Do ◯ Do not have a final finding of patient or resident abuse If you checked either "Have" and/or "Do", please provide a brief explanation. (Optional)
8.	My current mailing or home address is indicated in Section 1 of this form.
9.	I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the re-disclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency in accordance with applicable laws. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own.

Applicant Signature: | Date: ☐☐/☐☐/☐☐☐☐

Name and Signature of Parent or Legal Guardian: (if subject individual is under 18 years of age) | Date: ☐☐/☐☐/☐☐☐☐

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name: | Operating License Number (PFI):

Print Name of Authorized Person: | Title:

Signature of Authorized Person: | Date: ☐☐/☐☐/☐☐☐☐

This form is to be retained by the agency. Do not forward to the DOH CHRC

NYS Department of Health | CRIMINAL HISTORY RECORD CHECK

Resubmission ○

Type or print all information - USE CAPITAL LETTERS.
Inaccurate, incomplete or illegible information will delay processing.

DOH use only. Leave blank

SECTION 1 - SUBJECT INDIVIDUAL INFORMATION

Social Security Number* ___ - ___ - ____ Date of Birth mm/dd/yyyy __ / __ / ____

LAST Name _____ FIRST Name _____ M.I. _

Maiden Name _____ Alias (AKA) _____

Street Nmbr _____ Street Name _____ Apt # _____

City _____ St __ Zip _____ Home Phone ___ - ___ - ____

Sex _ Birth Country/Place _____ Cell Phone ___ - ___ - ____

Race _ Height (ft-inch) _ - __ Weight (lbs) ___ Hair ___ Eyes ___

SECTION 2 - SUBJECT INDIVIDUAL IDENTIFICATION

Please Select the Type of **PICTURE IDENTIFICATION** (select one):

○ Drivers License/ DMV ID ○ Passport ○ Miltary ○ School ○ Other Identify: _____

Issuing State/Country/Armed Force/School: _____ ID Number _____ ID Expire Date mm/dd/yy __ / __ / __

SECTION 3 - AGENCY IDENTIFICATION

○ Nursing Home ○ CHHA ○ LTHHCP PFI# ____ ○ LHCSA LICENSE # _____

Full name of Agency where applicant will be working _____ Telephone number with area code ___ - ___ - ____

Authorized Person LAST Name _____ FIRST Name _____

Agency's Street Nmbr _____ Street Name _____

City _____ State __ Zip _____

Authorized Party's e-mail: _____

The subject individual, whose identification I have confirmed, will provide direct care or supervision to individuals receiving care and/or services and is a subject individual concerning whom a criminal history record check is required by law (Article 28-E of the Public Health Law and Section 845-B of the Executive Law). I understand that the results of the criminal history record check will be used solely for purposes authorized by law and I will abide by the confidentiality requirements set forth in law. Informed consent (DOH CHRC Form 102) has been given by the subject individual and is on file.

Signature of Agency Authorized Person: _____ Date: __ / __ / __ (MM / DD / YY)

SECTION 4 - FINGERPRINTING METHOD/IDENTIFICATION

Fingerprint Method:
○ Ink & Roll
○ Live Scan

Name & Address of Location where fingerprint services were performed _____

City _____ State __ Zip _____

Identification verified before fingerprinting: (refer to Instruction #4)
○ Yes
○ No

The subject individual, whose identification I have confirmed, appeared before me for fingerprinting. I secured his/her fingerprints via the method indicated.

Signature: _____

First Name: _____

Last Name: _____

Title: _____

Date Fingerprinted __ / __ / ____ (MM / DD / Y Y Y Y)

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*The Authorized Person shall inform the subject individual that disclosure of the Social Security Number (SSN) is voluntary and not mandatory and that it will be used to assist DOH-CHRC Unit in performing criminal history record checks.