



Employment Verification Request

Release of Information: I hereby authorize In Flight, Inc. to investigate all information pertinent to my application for employment to determine my qualifications for employment, which may include contacting former and/or current employers or any person or entity. I hereby authorize all persons and entities having information relevant to my application to provide that information to In Flight, Inc. I understand that any offer of employment may be rescinded, or my employment terminated if my references are inadequate or unacceptable to In Flight, Inc., or if I violate any of the provisions of the certification.

Name of Applicant: _____

Position applied for: _____

Signature of Applicant: _____ Date: _____

Previous Employer: _____

Contact Information: _____

Position Held: _____ Dates of Employment: _____

Please return to Cassandra Crespo, Human Resources Assistant, via FAX at (845) 835-6288

To be filled out by Previous Employer:

Please Clarify the Following:

Previous Position Title: _____

Dates of Employment: From: _____ To: _____

Name: _____ Title: _____

(Of person supplying information)

Contact Information: _____

Signature: _____

845.835.6060

PO Box 326 Red Hook, NY 12571

www.InFlightInc.org

At In Flight, Inc. we empower people with intellectual and developmental disabilities, to reach for hopes and dreams and support a meaningful quality of life.

DISCLOSURE AND RELEASE

In connection with my application for membership or employment (including contract for services) with _____, I understand that consumer
(Organization)
reports, which may contain public record information, may be requested and obtained.

These reports may include information related to my previous driving record including court actions, citations, license suspensions and revocations.

I AUTHORIZE, WITHOUT RESERVATION, ANY PARTY OR AGENCY CONTACTED TO FURNISH THE ABOVE-MENTIONED INFORMATION.

I have the right to obtain information as to the name, address and phone number of any agency providing such information and further, may request of that agency, upon proper identification, the nature and substance of all information in its files on me at the time of my request, including all sources of information as well as the recipients of any reports on me which that agency has previously furnished within the two (2) year period preceding my request.

This authorization shall remain on file and shall serve as ongoing authorization for the organization to procure Motor Vehicle Reports at any time during my employment, membership or contract period.

Print Name

Social Security Number

Signature

Date

Driver License Number

State

date of birth

NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit
 161 Delaware Avenue
 Delmar, NY 12054
 Fax: 518-549-0464

Request for Staff Exclusion List Check Form



The Justice Center maintains a Vulnerable Persons Central Register (VPCR) that includes a Staff Exclusion List (SEL) containing the names of individuals who have committed serious acts of abuse and are deemed ineligible to work in a position involving regular and substantial contact with a service recipient. Providers must request the Justice Center to conduct a check of the SEL before determining whether to hire or otherwise allow "any person" to have regular and substantial contact with a service recipient. "Any person" can include an employee, administrator, consultant, intern, volunteer, or contractor.

Instructions:

1. The provider's Authorized Person must complete this form and fax it to the Justice Center's Criminal Background Check (CBC) unit for an applicant under serious consideration to be hired or otherwise permitted to have regular and substantial contact with a service recipient.
2. The Justice Center's CBC unit will send the Authorized Person an email indicating the results of the SEL check.
3. If the Applicant is on the SEL, he or she may not be hired in a position involving regular and substantial contact with a service recipient in a facility or provider agency defined in Social Services Law §488(4) or by other providers of services in programs licensed or certified by the Office of Mental Health, Office for People With Developmental Disabilities, Office of Alcohol and Substance Abuse Services, Office of Children and Family Services, Department of Health and State Education Department.
4. If the Applicant is on the SEL, certain other providers have discretion whether to hire the individual as provided in Social Services Law §495(3).
5. If the Applicant is not on the SEL, a criminal background check through the Justice Center, if required, and an inquiry of the Statewide Central Register of Child Abuse and Maltreatment through the Office of Children and Family Services, if required, must be conducted.

Part 1. Applicant Information (Please Print)

Last Name:		First Name:		MI:
Date of Birth:	Social Security Number:		Alien Reg#:	
Applicant address:		Applicant type:		
Facility/Provider Name: In Flight Inc. Address: PO Box 326 Red Hook, NY 12571				
State Oversight Agency: OMH <u>OPWDD</u> OCFS DOH SED OASAS				Please circle appropriate agency(ies)

Part 2. Authorized Person Information Please print clearly

Name: (Please Print)	Teresa Stivala	Email: tstivala@inflightinc.org
Signature:		Phone: 845-835-6060
Facility/Provider name:	In Flight Inc.	Address: PO Box 326 Red Hook, NY 12571

Fingerprint Applicant Info Sheet

Applicant Name First Name _____ Last Name _____

Date of Birth: _____

Methods of Contact (If there is a problem with the prints, MorphoTrust requires a way to reach out to the Applicant to advise that they need to be re-printed.)

Preferred Contact Method (check one): Phone Email

Phone Number _____

Email _____ (not required unless preferred method of contact)

Citizenship

Country of Birth: _____

If US, state of birth: _____

Country of Citizenship: _____

Personal Questions

Have you ever used a maiden/previous name? Yes ____ No ____

Have you ever used an alias? Yes ____ No ____

Is your mailing address the same as your residential address? Yes ____ No ____

Personal Info

Height: ____ Feet ____ Inches Weight: ____

Eye Color:	Black	Hair Color:	Bald
	Blue		Black
	Brown		Blond
	Gray		Brown
	Green		Gray
	Hazel		Red
	Maroon		Sandy
	Pink		White

Preferred language: _____ Gender: Male ____ Female ____ Race: American Indian

Asian

Black

Ethnicity: Hispanic Non-Hispanic Unknown

White

Unknown

Applicant Home Address Number Street Name

Unit Designator (Apt # **required** If applicable)

Country City State Zip Code

Identification Document

Please select the required documents to bring to your enrollment.

– Choose One –

- Commercial Driver's License issued by a State or outlying possession of the U.S.
- Department of Defense Common Access Card
- Driver's License PERMIT issued by a State or outlying possession of the U.S.
- Driver's License issued by a State or outlying possession of the U.S.
- Employment Authorization Card/Document (I-766) with Photo
- Enhanced Driver's License (EDL)
- Enhanced Tribal Card (ETC)
- Federal ID Card with a seal or logo from a Federal agency
- Merchant Mariner Document (MMD)
- Military Dependent's Card
- Military ID Card
- Military ID Card (retired)
- Passport Book or Card
- Permanent Resident Card / Green Card (I-551)
- Photo ID Waiver for Minors
- State ID Card (or outlying possession of the U.S.) with a seal or logo from State or State Agency
- Uniformed Services Identification Card (Form DD-1172-2)

Does the name you are enrolling under match the name on the document selected? Yes No



Justice Center for the Protection of People with Special Needs

Applicant Consent Form for Fingerprinting for Justice Center Criminal Background Check (CBC)

NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit

Part 1. Applicant Information (Please Print)

Last Name:	First Name:	MI:
Date of Birth:	Applicant type: Employee _____ Volunteer _____ Family Care _____ Operator _____	
Applicant address, city state:		Social Security Number:
Facility/Provider Name:		

Part 2. Attestation

1. I have been advised that as part of the application process, the facility or provider agency listed above must request a background check with the NYS Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI) and the Justice Center must review and evaluate the results received from DCJS and the FBI. A conviction for certain crimes may affect my suitability for employment in this position.
2. I consent to having my fingerprints taken and submitted to DCJS and the FBI and consent to the Justice Center sharing with the facility or provider agency listed above a summary of the NYS criminal history information, if any, returned by DCJS, as part of its background investigation of my suitability for employment or volunteer service, or for certification as a natural person operator.
3. I have been advised that procedures exist for me to obtain, review and, if necessary, seek correction of my criminal history information pursuant to regulations established by DCJS in 9 NYCRR Part 6050, and the FBI, as applicable.
4. I have been advised that I have the right to withdraw my application for employment or volunteer service, or certification as a natural person operator, without prejudice, any time before employment, volunteer service, or certification as a natural person operator is offered or declined, regardless of whether the authorized person of the facility or provider agency has reviewed the summary of any criminal history information.
5. I have been advised that the results of the criminal background check forwarded to the Justice Center shall be confidential pursuant to the applicable federal and state laws, rules and regulations, and shall only be disclosed to persons authorized by law. Criminal history information will be considered pursuant to Article 23-A of the NYS Correction Law in making hiring determinations.
6. I affirm that the fingerprints submitted will be my own and that the information I have provided is true, complete and accurate.
7. I certify to the best of my knowledge that I: (check as appropriate)
 - (a) _____ have not been convicted of a crime.
 - (b) _____ have been convicted of a crime in NY or other jurisdiction.
 - (c) _____ have pending arrest charges.
 If (b) or (c) is checked, provide details: _____

8. I have been advised that my social security number is being requested so that the Justice Center may check whether I am on the Staff Exclusion List as required by Social Services Law and will be performed prior to the criminal history information check.

You have not been convicted of a crime if:

- a. Your conviction was sealed; dismissed; reversed; resulted in a youthful offender (YO) or juvenile delinquency (JD) adjudication; resulted in a conviction for a non-criminal violation offense; or if you were acquitted;
- b. you received an Adjudgment in Contemplation of Dismissal (ACD) and the adjournment period has elapsed; or
- c. you withdrew your plea after completing a treatment program, and were not convicted of a felony or misdemeanor.

Applicant Signature	Date:
Guardian signature if under 18	Date:

Part 3

Facility or Provider Agency Authorized Person Information

Authorized Person Name:	Teresa Stivala	Title: Vice President of Human Resources
Signature:		Email: tstivala@inflightinc.org

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STATEWIDE CENTRAL REGISTER DATABASE CHECK
Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER (Area Code): () -
PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER:			The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form <u>FOR ALL CATEGORIES:</u> Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS/MARRIAGE SECTIONS THAT APPLY. IF NONE, STATE "NONE" List RELATIONSHIP in the fields below <i>(see reverse side for instructions) Attach additional page if necessary.</i>	
AGENCY NAME:				
AGENCY LIAISON:				
STREET ADDRESS:				
CITY:	STATE:	ZIP CODE:		

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA

***PLEASE TYPE OR PRINT CLEARLY**

IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK THIS BOX.

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH
APPLICANT				
APPLICANT MAIDEN/ALIAS/MARRIED NAME				

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) / /	TO (Mo/Yr) / /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) / /	TO (Mo/Yr) / /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) / /	TO (Mo/Yr) / /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) / /	TO (Mo/Yr) / /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) / /	TO (Mo/Yr) / /

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE / /
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APPLICANT'S SIGNATURE	DATE / /
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EIGHTEEN YEARS OLD OR OVER:

I understand that as a person eighteen-years of age or over in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE / /
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SIGNATURE	DATE / /
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