

APPLICATION FOR HEALTH WORKER RETRAINING INITIATIVE
THIS APPLICATION MUST BE ENTIRELY COMPLETED.
PLEASE SEND US ALL NECESSARY PAPERWORK
ALONG WITH THIS APPLICATION

PLEASE PRINT CLEARLY

Date: _____ How did you hear about us? _____

Personal Information: Name: _____
Last First

Present Address: _____

 Email: _____
 (Please check daily for information from LPN Program from email: nursing@snya.org)

Phone Number: (home) _____ (cell) _____

Have you ever been arrested or convicted of a crime? Yes ___ No ___

Are you prevented from lawfully becoming employed in this country because of visa or immigration status? Yes ___ No ___

Education:

	Name of school	Number of years attended	Did you graduate?
High School (GED)			
College			

Health Care Employment History (Please list your most recent employment first)

Dates From/To	Company Name	Address City/State/Zip/Phone	Healthcare Position/Title	Reason for leaving

In Case of Emergency, Contact: _____
Name Relationship Phone #

"I certify that all the information submitted by me on this application is true and complete, and I understand that if any false information, omissions, or misrepresentations are discovered, my application may be rejected.

 Signature of Applicant

Southern New York Association – 39 Broadway, Suite 1710 – New York, NY 10006
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