



Ellicott Police Department

215 South Work Street
Falconer NY 14733
(716) 665-7083

Date Turned In: _____

APPLICATION FOR EMPLOYMENT

LAST NAME: _____ FIRST NAME: _____ M.I. _____

Street address: _____

City: _____ State: _____ Zip: _____

Phone: () _____ Marital Status: S M D (Circle one)

Date of Birth: _____ Social Security Number: _____

Do you possess a valid N.Y.S. pistol permit? _____ Permit #: _____

Do you have *any* medical problem(s)? Y or N (Circle One)

IF "YES", please note problem(s): _____

Do you speak any foreign language(s)? Y or N (Circle One)

IF "YES", what language(s)? _____

Do you have any computer training? Y or N (Circle One)

IF "YES", where? _____

Can you type? Y or N (Circle One)

IF "YES", approximately how many words per minute? _____

Please list any medical training/certification(s) you possess, ie CPR, First Aid, EMT, etc...

Do you possess a valid driver's license? Y or N (Circle One)

IF "YES", please list STATE, EXPIRATION DATE, LICENSE NUMBER

Have you ever served in the Armed Forces? Y or N (Circle One)

IF "YES", please list Branch, Date of Service, and type of Discharge. _____

Are you an active member of the military reserves? Y or N (Circle One)

Have you ever attended/completed a basic training academy for Police Officer? Y or N (Circle One)
IF "YES", please list where and date of completion: _____

Are you currently on a civil service list for Police? Y or N (Circle One)
IF "YES", with what agencies and your score? _____

Have you interviewed *or working for* any other Police Agency? Y or N (Circle One)
IF "YES", please list: _____

WORK EXPERIENCE (Please list the last 3, starting with most recent)

1. NAME: _____
Street Address: _____
City: _____ STATE: _____ ZIP: _____
Phone: () _____ Supervisor: _____
Length of employment FROM: _____ TO: _____
Why did you leave? _____

2. NAME: _____
Street Address: _____
City: _____ STATE: _____ ZIP: _____
Phone: () _____ Supervisor: _____
Length of employment FROM: _____ TO: _____
Why did you leave? _____

3. Name: _____
Street Address: _____
City: _____ STATE: _____ ZIP: _____
Phone: () _____ Supervisor: _____
Length of employment FROM: _____ TO: _____
Why did you leave? _____

4. Name: _____
Street Address: _____
City: _____ STATE: _____ ZIP: _____
Phone: () _____ Supervisor: _____
Length of employment FROM: _____ TO: _____
Why did you leave? _____

EDUCATION: *(Please list from the most recent noting all college and high school information.)*

1. Name of School: _____
Major(s): _____
Degree/Diploma received: _____
Date of attendance: FROM: _____ TO: _____

2. Name of School: _____
Major(s): _____
Degree/Diploma received: _____
Date of attendance: FROM: _____ TO: _____

3. Name of School: _____
Major(s): _____
Degree/Diploma received: _____
Date of attendance: FROM: _____ TO: _____

REFERENCES: *(Please list three that are NOT family or former employers)*

1. NAME: _____
Address: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: () _____

2. NAME: _____
Address: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: () _____

3. NAME: _____

Address: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: () _____

Information you feel may be important, thing we may find in a background check, i.e. garnishes, arrests, or other personal issues. (Use back side or additional blank sheets if necessary):

Sports/hobbies you are interested in:

I affirm that the statements made on this application, including any attached papers, are true and correct under the penalties of perjury.

_____ Date: _____
SIGNATURE OF APPLICANT

***** ATTACH A RECENT (LAST 30 DAYS) 3X5
COLOR PHOTO (INKJET OR LASER PRINTER IS OK)
OF YOURSELF TO APPLICATION *****

**AUTHORIZATION AND RELEASE
OF MILITARY AND VETERANS RECORDS**

To Whom It May Concern:

1, _____, hereby authorize and instruct any person, officer, agency, firm, organization, or institution to release and deliver to the Town of Ellicott or its designated representative, upon a production of this document, or a copy of it, any and all records, documents, or information relating to any period of service that I have had in any of the Armed Forces of the United States, of any other country or territory, or in the Reserve Forces or National Guard, including, but not limited to:

1. Any applications or documents related to my entry into such service;
2. Any performance evaluations or ratings relative to the quality of such service;
3. Any records or information concerning any disciplinary actions during such term of service;
4. Any and all records and information concerning the termination of such service, and the character and designation of such termination;
5. Any and all information concerning any awards, medals, decoration, or commendation earned during such service;
6. Any and all records, documents, or information relevant to my character, integrity, temperance, conduct or capabilities.

This authorization shall include the right to inspect and copy any such documentation or record by the Town of Ellicott or its designated representative, and shall further supersede and make ineffective any restriction, letter, document, instruction, or authorization filed by me, or any person on my behalf, with any such person, officer, agency, firm, institution, or organization, if such document would limit or restrict the grant of power hereunder.

I hereby authorize the Town of Ellicott to make copies of this authorization and release, and to give a copy to any person, officer, agency, firm, institution, or organization requesting same from whom the above information has been requested.

Dated: _____

Applicant's Signature

On _____, before me, the subscriber, came _____, known to me

Date

and known to me to be the person described in the foregoing instrument and who executed same, and (s)he duly acknowledged that (s)he executed the same.

Notary Public/Commissioner of Deeds

**AUTHORIZATION AND RELEASE
FOR EMPLOYMENT/UNEMPLOYMENT RECORDS**

To Whom It May Concern:

I, _____, hereby authorize and instruct any person, firm, company, agency, or organization of which I am a present or former employee, or to which I made application for employment or unemployment benefits, to release and deliver to the Town of Ellicott or its designated representative, upon production of this document, or a copy of it, any and all information or records relating to said employment/unemployment or application, including, but not limited to:

1. My original application;
2. My punctuality records;
3. Any performance or quality of work evaluation;
4. Records relating to any disciplinary actions related to my employ;
5. Records relating to the reasons for termination from said employment or for rejection of my application for employment;
6. Unemployment records or information concerning application, rejection, benefits entitled/received, dates/period of receipt, reason for termination or judicial action taken or contemplated;
7. Any other information concerning my character, integrity, maturity, or capabilities contained in any file maintained by such person, agency, firm, company, or organization for any purpose whatsoever.

This authorization shall include the right of inspection and copying of any document contained in said records or files, by the Town of Ellicott or its designated representative. This authorization shall further supersede and make ineffective any restriction, letter, document, instruction or authorization previously filed by me or with any person on my behalf with any such person, firm, company, agency, or organization, if such document would limit or restrict the grant of power hereunder.

I hereby further authorize the Town of Ellicott to make copies of this authorization and release, to give such a copy to any person, firm, company, agency, or organization requesting same from whom the above information has been requested.

Dated: _____

Applicant's Signature

On _____, before me, the subscriber, came _____, known to me

Date

and known to me to be the person described in the foregoing instrument and who executed same, and (s)he duly acknowledged that (s)he executed the same.

Notary Public/Commissioner of Deeds

**AUTHORIZATION AND RELEASE
FOR EDUCATIONAL RECORDS**

To Whom It May Concern:

I, _____, hereby authorize and instruct any person, agency, firm, or institution of which I am a present or former student, matriculated, or otherwise, or to which I made application to pursue any course of study, to release and deliver to the Town of Ellicott, or its designated representative, upon production of this document, or a copy of it, training, or application, including, but not limited to:

1. Any evaluation or comments of any person relating to the quality of my work or to my performance as a student;
2. Records relating to any disciplinary action taken against me, whether concerning my academic performance or my conduct;
3. Records relating to the reason or details of my termination from said course of study, or any class or part thereof;
4. Any other information concerning my character, integrity, maturity, or capabilities contained in any file maintained by such person, agency, firm, or institution, for any purpose whatsoever.

This authorization shall include the right of inspection and copying of any document contained in said records or files, by the Town of Ellicott or its designated representative. This authorization shall further supersede and make ineffective any restriction letter, document, instruction, or authorization previously filed by me or with any person on my behalf with any such person, agency, firm, or institution, if such document would limit or restrict the grant of power hereunder.

Dated: _____

Applicant's Signature

On _____ before me, the subscriber, came _____, known to me
Date

and known to me to be the person described in the foregoing instrument and who executed same, and (s)he duly acknowledged that (s)he executed the same.

Notary Public/Commissioner of Deeds

MEDICAL HISTORY

READ EACH OF THE FOLLOWING ITEMS CAREFULLY. CHECK YES FOR ANY THAT YOU NOW HAVE, OR HAVE HAD IN THE PAST, AND NO FOR THOSE WHICH YOU HAVE NOT HAD.

YES	NO		()	()	
()	()	1. Asthma	()	()	47.Malaria
()	()	2. Hayfever	()	()	48.Rheumatic Fever
()	()	3. Other Allergies	()	()	49.Veneral Disease
()	()	4. Anemia	()	()	50.Any psychiatric exam or counsel
()	()	5. Enlarged Spleen	()	()	51.Reapeasted Headaches
()	()	6. Bleeding from:	()	()	52.Fainting attacks
		() Nose () Lung	()	()	53.Head Injury
		() Urine () Stool	()	()	54.Epilepsy, fits
()	()	7. Back injury or condition	()	()	55.Convulsive seizures
()	()	8. Amputation	()	()	56.Blackouts
()	()	9. Fracture / Sprain	()	()	57.Hemorrhoids, hernia
()	()	10.Any joint condition	()	()	58.Albumin / sugar in urine
()	()	11.Carilage injury	()	()	59.Any kidney condition
()	()	12.Arthritis / Bursitis	()	()	60.Any gland condition
()	()	13.Foot Trouble	()	()	61.Any Nose condition
()	()	14.Other bone condition	()	()	62.Any speech defect
()	()	15.Adnormal Blood Pressure	()	()	63.V.A. Medical claims
()	()	16.Heart murmur / Condition	()	()	64.Received disability payments
()	()	17.Varicose Veins	()	()	65.Any liver condition
()	()	18. Perforated eardrum	()	()	66.Infantile paralysis
()	()	19.Mastoid	()	()	67.Other infection
()	()	20.Other ear Condition	()	()	68.Tetnus immunization
()	()	21.Bedwetting	()	()	69.Any skin disorder
()	()	22.Sleep Walking	()	()	70.AIDS or ARC
()	()	23.Alcoholism	()	()	71.Other – describe
()	()	24.Nervousness	()	()	72.Currently taking medication
()	()	25.Use of Narcotic drugs			
()	()	26.Any mental disorder			
()	()	27.Family mental disorder			
()	()	28.Sinusitis			
()	()	29.Tuberculosis			
()	()	30.Chronic Bronchitis			
()	()	31.Pneumonia / Pleurisy			
()	()	32.Diabetes			
()	()	33.Cysts-Tumors			
()	()	34.Any 1-Y or 4-F draft classification			

YES	NO	
()	()	35.Rejection on any medical exam
()	()	36. Defective color perception
()	()	37.Eyeglasses / Contact Lenses
()	()	38.Other Eye Condition
()	()	40.Gall Bladder condition
()	()	41.Hepatitis or Jaundice
()	()	42.Undescended testicle
()	()	43.Varicocele or hydrocele
()	()	44.Urethritis
()	()	45.Hospitalized for any reason
()	()	46.Any Surgery

Medical Continued

For each of the previous items checked "YES", give the item number and a brief explanation below. If hospitalized, give name and address of hospital.

<u>ITEM No.</u>	<u>DATE</u>	<u>DETAILS</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List the following information on your current, or most recent, family doctor.

Name: _____

Address: _____

Phone: () _____

Has any physician ever prescribed any anti-depressant, tranquilizer or anti-psychotic drug for your use? No ___ Yes ___ If YES, give details:

Do you now have, or have you ever had, any physical or psychiatric condition, which has impaired your ability to function in any employment or educational setting other than previously listed in this section? No ___ YES ___ If yes, give details:

List any other medical / mental condition that we should be made aware of:

