

KinderKare Early Intervention Program

Application for Hire

Personal Information

Date of Application: _____	Name: _____	Profession: _____
	Dr., Mr. Ms. Mrs.	
Home Phone: _____	Cell Phone: _____	Beeper: _____
Fax: _____	E-mail address: _____	Professional Degree: _____
		MA, MS, BS, AS, MSW
Address: _____	City: _____	State: _____ Zip Code _____

Are you now or have you ever been the subject of disciplinary action by a State agency, licensing board, or professional organization? _____ If yes, when and why? _____

Have you ever had your professional license or certification suspended or revoked? _____ If yes, when and why? _____

Have a claim ever been submitted to your malpractice insurance? _____ If yes, why and when _____

Have you ever been convicted of a crime? _____ If yes, when and why? _____

Have you ever been barred from participating in the Medicare or Medicaid program? _____ If yes, when and why? _____

Have you ever been dismissed from employment? _____ If so, when and why? _____

Professional Experience

Date Month & Year (Present)	Name & Address	Job Description	Population Served Ages/Diagnoses
From: To:			
From: To:			
From: To:			

What other languages do you speak and write proficiently? _____

What languages that you have some understanding of? _____

Educational Experience

Date Month & Year (Present)	School Name & Address	Course Study Major/Minor	Degree Earned
From: To:			
From: To:			
From: To:			

List Educational Workshops you attended (with dates) beginning with the most recent: _____

Would you prefer to be contacted via email? _____ e-mail address: _____

Please list your availability for work: Full time () Part time () Mornings () Evenings ()
Afternoons () Weekends ()

Please describe your child preference or specialty: () 0-1 () 1-2 () 2-3 () 3-5

What disabilities do you prefer servicing? () Prematurity () Down Syndrome
() Autism () Cerebral Palsy

In addition to providing sessions, can you perform evaluations? _____

What neighborhoods in Nassau County can you service? (List by name or zip code) _____

What specialty training for various therapeutic approaches do you have? (NDT, sensory integration therapy, oral-motor therapy, hearing management) _____

All the information entered here is true and accurate: _____ Date: _____

Your signature