

## GENERAL ENROLLMENT FORM

(Please print clearly in blue or black ink. This form is strictly confidential.)  
All fields marked with an asterisk (\*) are required; do not leave them blank.

### SECTION I: MEMBER INFORMATION

\*MEMBER'S FULL NAME \_\_\_\_\_ \*DATE OF BIRTH \_\_\_\_\_

\*SOCIAL SECURITY NUMBER (LAST FOUR DIGITS) *Note: Certain programs may require you to provide your full Social Security Number.* \_\_\_\_\_

Have you participated in an 1199SEIU City Fund program in the past?  No  Yes

\*ADDRESS \_\_\_\_\_ \*CITY \_\_\_\_\_ \*STATE \_\_\_\_\_ \*ZIP CODE \_\_\_\_\_

HOME PHONE NUMBER \_\_\_\_\_ CELL PHONE NUMBER \_\_\_\_\_

I authorize the 1199SEIU Training and Employment Funds to send text messages to my cell phone. I understand that standard message and data rates may apply.

PREFERRED EMAIL \_\_\_\_\_ ALTERNATE EMAIL \_\_\_\_\_

\*Current marital status:  Married  Divorced  Widowed  Separated  Single  Domestic partnership

\*Member's gender:  Male  Female

NUMBER OF DEPENDENTS \_\_\_\_\_ If you were born outside of the United States (U.S.), what year did you enter the U.S.? \_\_\_\_\_

\*MEMBER'S COUNTRY OF BIRTH \_\_\_\_\_

\*Do you speak a language other than English?  Yes  No If "No," please go to the "Ethnicity" question below. If "Yes," please continue to the next question.

\*Is English your first language?  Yes  No If "No," what is your first language? \_\_\_\_\_

Do you consider yourself bilingual?  No  Yes If "Yes," what are the two languages you speak? \_\_\_\_\_

\*Ethnicity (please check only one):  American Indian/Alaskan Native  Black or African-American (Non-Hispanic)  Native Hawaiian or other Pacific Islander  
 Asian  Hispanic or Latino/a  White (Non-Hispanic)

### SECTION II: EMPLOYMENT INFORMATION

\*Union affiliation (please check only one):  1199SEIU member  Not a union member  Other union affiliation (specify): \_\_\_\_\_

\*Per diem:  No  Yes \*Job status (please check only one):  Permanent  Temporary  Laid off  Retired

\*Job schedule (please check only one):  Full time  Part time

\*CURRENT EMPLOYER'S NAME (DO NOT ABBREVIATE. IF LAID OFF OR RETIRED, PLEASE ENTER THE NAME OF YOUR FORMER EMPLOYER.) \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

\*DEPARTMENT \_\_\_\_\_ \*JOB TITLE \_\_\_\_\_

WORK PHONE NUMBER \_\_\_\_\_ \*DATE OF HIRE \_\_\_\_\_

\*AVERAGE NUMBER OF HOURS WORKED PER WEEK \_\_\_\_\_ \*Rate of pay: \$ \_\_\_\_\_  Hourly  Yearly

Have you been with your current employer for less than one year?  No  Yes

IF "YES," PLEASE ENTER THE NAME OF YOUR PREVIOUS EMPLOYER (DO NOT ABBREVIATE) \_\_\_\_\_

Employment dates with previous employer: \_\_\_\_\_ START DATE \_\_\_\_\_ END DATE \_\_\_\_\_

**SECTION III: EDUCATION HISTORY**

Where did you complete your highest level of education?  U.S.  Non-U.S. country (specify): \_\_\_\_\_

What is the highest level of education you have completed? (please check only one)

- |  |   |
|--|---|
| <input type="checkbox"/> Elementary school (5th grade)   | <input type="checkbox"/> Associate degree                                   |
| <input type="checkbox"/> Middle school (8th grade)   | <input type="checkbox"/> Bachelor's degree                                  |
| <input type="checkbox"/> High school (high school diploma or GED)  | <input type="checkbox"/> Post-bachelor/Graduate certificate                 |
| <input type="checkbox"/> Spanish GED   | <input type="checkbox"/> Master's degree                                    |
| <input type="checkbox"/> Some college, non-completion  | <input type="checkbox"/> Professional degree (PharmD, PsyD, MD, EdD, other) |
| <input type="checkbox"/> Post-secondary certificate (vocational or occupational, LPN, CNA, CASAC, other) | <input type="checkbox"/> Doctoral degree (PhD)                              |

Do you have any foreign credentials?  No  Yes If "Yes," please list credentials: \_\_\_\_\_

Have your credentials been evaluated?  No  Yes If "Yes," what is the U.S. equivalent? \_\_\_\_\_

List any health-related training, certifications or licensures that you have received from U.S. institutions:

1. DEGREE/CERTIFICATE TYPE \_\_\_\_\_ SCHOOL \_\_\_\_\_

CERT./LIC. # \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_

2. DEGREE/CERTIFICATE TYPE \_\_\_\_\_ SCHOOL \_\_\_\_\_

CERT./LIC. # \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_

**SECTION IV: TRAINING APPLICATION**

- Requesting (please check only one):**
- |  |  |
|--|--|
| <input type="checkbox"/> Licensure renewal fee reimbursement                   | <input type="checkbox"/> Certification renewal fee reimbursement |
| <input type="checkbox"/> Continuing professional education (CPE) reimbursement | <input type="checkbox"/> Degree program tuition reimbursement    |
| <input type="checkbox"/> Credit-bearing certification program reimbursement    | <input type="checkbox"/> Access to CE Direct                     |

**Check all applicable boxes that indicate what you are applying for:** Term:  Fall  Winter  Spring  Summer Year:  2017  2018  2019

START DATE \_\_\_\_\_ END DATE (FOR CPE AND LICENSURE/CERTIFICATION PROGRAMS) OR EXPECTED GRADUATION DATE (FOR DEGREE PROGRAMS) \_\_\_\_\_

SCHOOL (FOR DEGREE PROGRAMS) / TRAINING INSTITUTION (FOR CPE PROGRAMS) / ISSUING ORGANIZATION (FOR LICENSURE/CERTIFICATION PROGRAMS) \_\_\_\_\_

- Program of study goal (please check only one):**
- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Associate degree  | <input type="checkbox"/> Bachelor's degree     | <input type="checkbox"/> Master's degree            | <input type="checkbox"/> Doctoral degree |
| <input type="checkbox"/> Licensure renewal | <input type="checkbox"/> Certification renewal | <input type="checkbox"/> Credit-bearing certificate |  |

License, Certification or Course	Name of course, if applicable	Course number, if applicable	Tuition (cost per credit)

**PLEASE READ, SIGN AND DATE BELOW. IF YOU DO NOT SIGN AND DATE THIS FORM, IT WILL NOT BE VALID.**

I hereby attest that the information given above is correct to the best of my knowledge. I also authorize the 1199SEIU/City of New York Education, Child and Elder Care Fund ("1199SEIU City Fund") to verify the above information. I understand that the 1199SEIU City Fund reserves the right to deny me eligibility if I present materially false information on this form. If selected for a program, I agree to abide by the regulations set forth by the 1199SEIU City Fund and the institution where I am placed. I also authorize the 1199SEIU City Fund to release all identifiable information to appropriate funding sources.

MEMBER'S FULL NAME (PRINT) \_\_\_\_\_

**X** \_\_\_\_\_  
MEMBER'S SIGNATURE DATE