APPLICATION FOR NEW YORK STATE GOVERNOR'S PROGRAM TO HIRE INDIVIDUALS WITH DISABILITIES UNDER SECTIONS 55-b AND 55-c OF THE CIVIL SERVICE LAW

The following is an application for the Governor's Programs to Hire Persons with Disabilities: the 55b and 55c Programs. Please review the information very carefully and be sure it is complete before you mail it in.

Please note that the application includes a Physician's Questionnaire that **must be completed by your doctor.** See page two of the application for more information regarding medical documentation.

If you are a **Veteran** with a disability rating of 20% or more from the VA, then it is not necessary to complete the Physician's Questionnaire if you can send us a copy of your **VA Rating Decision Letter**. The letter must include both the rating and the **diagnosis** of your disability.

Failure to include the Physician's Questionnaire or the VA Rating Decision letter with your application, or insufficient medical documentation, will slow down the review of your application.

Once you have completed the application, mail it to:

NYS Department of Civil Service
55-b/c Programs
55 Mohawk Street
Cohoes, NY 12047

Your completed application should include the following:

- Application Form DPM-1
- Physician's Questionnaire Form DPM-60
- Your Resume

If you are a **Veteran**, your application must also include:

- a copy of your DD-214 paperwork

You are welcome to contact our staff with any questions you have: we can be reached at 518-233-3118 or, outside the 518 area code, call our toll free number, 1-866-297-4356.

Thank you for your interest in the Governor's Programs to Hire Persons with Disabilities.

APPLICATION FOR NEW YORK STATE GOVERNOR'S PROGRAM TO HIRE PERSONS WITH DISABILITIES UNDER SECTIONS 55-b AND 55-c OF THE CIVIL SERVICE LAW

Last Name	First Name	MI	Social Security Number

Mailing Address: No., Street, Apt., or P.O. Box:		
City	State	Zip Code

Email Address	Day Phone

What counties are you willing to work in:

Present Employer:

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION

The information which you are providing on this application is being requested pursuant to Sections 55-b and 55-c and Section 50 (3) of the Civil Service Law for the principal purpose of determining the eligibility of applicants to participate in these programs. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly paragraphs (b), (e), and (f) of such Law. Failure to provide this information may result in an inability to process your application. This information will be maintained at the New York State Department of Civil Service, Alfred E. Smith State Office Bldg., Albany, New York 12239. For further information, relating only to the Personal Privacy Protection Law, call (518) 457-9375. For information, relating to this form, please call (518) 233-3118.

ELIGIBILITY FOR EMPLOYMENT

You must be legally eligible to work in the United States at the time of appointment and throughout your employment with New York State. If appointed, you must produce documents that establish your identity and eligibility to work in the United States, as required by the Federal Immigration Reform and Control Act of 1986, and the Immigration and Nationality Act.

I affirm under penalties of perjury that all statements made on this application (including any attached papers) are true. I understand that all statements made by me in connection with this application are subject to investigation and verification and that a material misstatement or fraud may disqualify me from appointment and/or lead to revocation of my appointment.

Date (mm/dd/yyyy): _____

Please print any other name by which you are or have been known: _____

_____
Signature of Applicant

It is the policy of the New York State Department of Civil Service to provide for and promote equal opportunity in employment, compensation and other terms and conditions of employment without discrimination on the basis of age, race, creed, color, national origin, gender, sexual orientation, disability, Vietnam Era Veteran status, marital status or genetic predisposition or carrier status.

It is the policy of the New York State Department of Civil Service to provide qualified persons with disabilities equal opportunity to participate in and receive the benefits, services, programs and activities of the Department, and to provide such persons reasonable accommodations and reasonable modifications as are necessary to enjoy such equal opportunity, including accommodations in the examination process. Further, it is the policy of the Department to provide reasonable accommodations for religious observers.

Send Completed Application To:	**New York State Department of Civil Service** **55b/c Program** **55 Mohawk Street** **Cohoes, NY 12047**

CONFIDENTIAL MEDICAL STATEMENT OF DISABILITY:

Placement pursuant to Sections 55-b and 55-c of the Civil Service Law is limited to persons with physical or mental disabilities, but who are found otherwise qualified to perform satisfactorily the duties of a position.

It is the responsibility of the applicant to provide recent medical documentation in support of his or her application. Accordingly, applicants are required to submit Form DPM-60, which is to be completed, signed and dated, by his or her physician. A copy of Form DPM-60 is attached to this application.

If you are hearing impaired, you should also include an audiogram, if possible. If you have a learning disability, you must submit a copy of your most recent psychological testing, in lieu of Form DPM-60. If you are legally blind, you may submit a certificate of legal blindness, in lieu of Form DPM-60. This application will not be processed until the proper medical documentation is received.

The medical documentation will be evaluated by a physician of the Employee Health Service to determine your eligibility under Sections 55-b and 55-c of the Civil Service Law. Medical information will be held in strict confidence, to the greatest extent practicable.

ADVOCACY AGENCIES: If any agencies have provided you with, or are now providing you with, counseling services, please complete the following:

Advocacy Agency:		Advocacy Agency:	
Address:		Address:	
City:	State:	City:	State:
Counselor's Name:	Phone:	Counselor's Name:	Phone:

SERVICE IN THE ARMED FORCES OF THE UNITED STATES:

YES ☐	NO ☐	I expect to receive, or have already received, a discharge which was honorable or release under honorable circumstances from the Armed Forces of the United States. The "Armed Forces of the United States" means the Army, Navy, Marine Corps, Air Force and Coast Guard, including all components thereof, and the National Guard when in the service of the United States pursuant to call as provided by Law, on a full-time active duty basis other than active duty for training purposes.		
YES ☐	NO ☐	I am now serving, or have served, on an active duty basis other than active duty for training purposes during one or more of the following Time of War periods.		
		In the Armed Forces: • Aug. 2, 1990 to the date when the Persian Gulf hostilities ends: • Feb. 28, 1961 to May 7, 1975 • June 27, 1950 to Jan. 31, 1955 • Dec. 7, 1941 to Dec. 31, 1946	or earned the armed forces, navy, or marine corps expeditionary medal for service in: • (Panama) Dec. 20, 1989 to Jan. 31, 1990; • (Lebanon) June 1, 1983 to Dec., 1, 1987; • (Grenada) Oct. 23, 1983 to Nov. 21, 1983;	or in the U.S. Public Health Service: • June 26, 1950 to July 3, 1952; • July 29, 1945 to Sept. 2, 1945.
YES ☐	NO ☐	Copy of Discharge – DD-214 will be sent at a later date.		
YES ☐	NO ☐	Copy of Discharge – DD-214 is enclosed.		
YES ☐	NO ☐	I am a United States citizen or an alien lawfully admitted for permanent residence.		
YES ☐	NO ☐	I have a service connected disability rated at 10% or more by the US Department of Veterans Affairs. This disability was incurred during a "Time of War" period listed above.		

New York State Residency Requirement for Extra Credits as a War Time Veteran or Disabled Veteran: You will be required to provide proof of current New York State residency at time of appointment.

YOUR EDUCATION:

Do you have a High School or Equivalency Diploma? ☐ Yes ☐ No	If YES, name and location of High School or Issuing Governmental Authority:

College, University, Professional or Technical School(s):	Semester Credits Received	Quarter Hours Received	Type of Degree Received	Major Subject or Type of Course	Did You Graduate	Degree Expected
Name:					☐ Yes ☐ No	MO. YR. /
Address:			City:		State:	
Name:					☐ Yes ☐ No	MO. YR. /
Address:			City:		State:	

LICENSE OR CERTIFICATION:

Complete the following if a license, certificate or other authorization to practice a trade or profession is required.

Trade or Profession:	License Number:	Date License First Issued	Registration: From: MO. / YR. To: MO. / YR.	If you are not currently licensed check this box: ☐
Specialty:		Granted by (licensing agency):	City:	State:

DESCRIBE YOUR EXPERIENCE:

Beginning with your most recent, list all employment, military service, or volunteer experience. You are responsible for an accurate and clear description of your experience. Under DUTIES, describe the nature of the work which you personally performed, including the estimated percentage of time spent on each type of activity. If you supervised, state how many people and the nature of such supervision.

LENGTH OF EMPLOYMENT From: MO. / YR. To: MO. / YR.	FIRM NAME: ADDRESS: CITY AND STATE:
EARNINGS: Check One: Wk: ☐ Mo. ☐ Yr. ☐	DUTIES:
TYPE OF BUSINESS:	
YOUR EXACT TITLE:	
NAME OF YOUR SUPERVISOR:	
SUPERVISOR'S TITLE:	
No. of hours worked per week: (exclusive of overtime:	

LENGTH OF EMPLOYMENT From: MO. / YR. To: MO. / YR.	FIRM NAME: ADDRESS: CITY AND STATE:
EARNINGS: Check One: Wk: ☐ Mo. ☐ Yr. ☐	DUTIES:
TYPE OF BUSINESS:	
YOUR EXACT TITLE:	
NAME OF YOUR SUPERVISOR:	
SUPERVISOR'S TITLE:	
No. of hours worked per week: (exclusive of overtime:	

State of New York
Department of Civil Service
55 Mohawk Street
Cohoes, NY 12047

DIVISION OF STAFFING SERVICES

55-b/c Program
Physician's Questionnaire

DPM-60 (5/09L)

Documentation submitted to establish your medical eligibility for appointment consideration under Sections 55-b/c of the Civil Service Law must be current and must include the following information.

Please have your Physician complete this Questionnaire.

In some cases, you may need to attach additional documentation. If you have questions or concerns, we can be reached at 518-233-3118 or toll-free at 1-866-297-4356.

Name:	Social Security Number:
1) Diagnosis:	
2) A short summary of applicant's case history:	
3) Current treatment (including medications, therapy, prosthetics):	
4) Prognosis (Please indicate if impairment is permanent, long term, and/or if applicant is expected to recover fully):	
5) How does the impairment(s) limit the applicant's major life activities? (Major life activities include activities such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. If there are other life activities, which the applicant's disabilities limit, please note.)	
6) Is the applicant employable at this time?	
_____ Physician's Signature	Date: _____