INSTRUCTIONS:

This form is to be completed by a prospective employee or volunteer. Complete all fields. If exact dates are not known, give approximate dates. Submit the completed form to your potential employer or organization with which you are applying to volunteer.

State of New York OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

APPLICANT INFORMATION

1. NAME					
2. SOCIAL SECURITY NUMBER		3. DATE OF BIRTH			
4. MAILING ADDRESS (include Street Address, Apt. #, City, State, Zip and County					
5. PROVIDER OF SERVICES NAME	E				
6. List complete employment history to recent employment and list employee				ith the most	
Full Name of Employer	Location (e.g.,	city, state)	Start Date	End Date	

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Full Name of Employer	Location (a.g. city, stata)	Start Date	End Date
Full Name of Employer	Location (e.g., city, state)	Start Date	Eliu Date
8. List all volunteer work for the past	7 years and volunteer work serving people	with developmenta	l disabilities
	s no history. Use an additional sheet if nee		
Full Name of Agency/Organization	Location (e.g., city, state)	Start Date	End Date
I CERTIFY that the information provid	ed in this form is true and correct to the be	est of my knowledge	e and belief,
and authorize investigation of all inform	nation given.		
The provision of false information is gr	ounds for dismissal.		
CLCN A THE DE		D.A. TEE	
SIGNATURE:	DATE:		
	y that I have reviewed the employment/vo		
	owledge, the applicant has no employment/ridual designated as an "authorized person"		
receive criminal history information pur		who is aumorized	io request and
, 1			