Health IT (Information Technology) Workforce Program
Application for Admission

A. BACKGROUND INFORMATION:

Name: _____
(Last) (First) (MI)

Former last name(s): _____

Mailing address _____
(Number and Street or P.O Box#) (City) (State) (Zip)

Email address (not sunysuffolk.edu) _____

Telephone number(s): Home _____ Business _____ Cell _____

Date of Birth: Month _____ Day _____ Year _____

Gender: ☐ Male ☐ Female

Are you currently participating in any of the following programs?

☐ TANF ☐ Food Stamps ☐ Aid to the Blind or Totally Disabled ☐ Refuge Cash Assistance Other, Specify _____

Please select your ethnic/racial group:

☐ White, Non-Hispanic ☐ Black/African-American ☐ Hispanic/Latino ☐ Asian

☐ American Indian/ Alaska Native ☐ Native Hawaiian/other PacificIslander

Have you ever served in the U.S Armed Forces? ☐Yes ☐ No

Have you ever been suspended, dismissed or expelled from college for disciplinary reasons? ☐Yes ☐ No (required)

Have you ever been convicted of a crime? ☐Yes ☐ No (required)

B. RESIDENCY/CITIZENSHIP INFORMATION:

Resident of Long Island for prior 6 months ☐Yes ☐ No (Specify State) _____ (required)

Country of citizenship ☐ United States ☐ Other (Specify)

C. EDUCATION

☐ HS Diploma/GED ☐ Some College ☐ Associate Degree ☐ Bachelor's Degree ☐Master's Degree ☐ Doctoral Degree

College(s)_____ Major(s) _____

D. Employment

Are you currently employed: ☐Yes ☐ No **How Long Unemployed** _____

If YES, are you employed in: ☐ Health IT ☐ IT ☐ Healthcare ☐ Other _____

E. Industry Certificate/License: (Check all that apply)

A+ ☐ Network+ ☐ Security+ ☐ RHIA ☐ RHIT ☐ LPN ☐ RN ☐ MD ☐ NP ☐ PA ☐ OT

Other (list): _____

For Office Use Only: CRN #_____ **Health IT Online**

Student ID#_____Intake Date_____Completion Date _____

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Health IT Program TechHire (RESTORE) grant

First Name: _____ M.I: _____ Last Name: _____
Date of Birth (Required):_____ Age: _____ ☐ Male ☐ Female Social security# (Required) _____-_____-_____
Phone: _____ Email:_____
Address:_____
City State Zip

Please select your ethnic/racial group:

☐ White, Non-Hispanic ☐ Black/African-American ☐ Hispanic/Latino ☐ Asian
☐American Indian/ Alaska Native ☐ Native Hawaiian/other Pacific Islander

Education Background:
☐ HS Diploma ☐ GED ☐ Some College ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctoral Degree

Employment Status (Required)
- ☐ Employed Full-time
- ☐ Employed Part-Time
- ☐ Unemployed

School-aged Children
Parent/Guardian Yes ☐ No ☐
Single Parent Yes ☐ No☐
If yes to above, please enter number of children at each level
Preschool _____ Elementary _____ JHS _____ HS _____ College _____

Population Categories:
- ☐ Head of House Hold
- ☐ Low Income
- ☐ Disable
- ☐ Migrant
- ☐ Dislocated Worker
- ☐ Veterans
- ☐ Homeless
- ☐ Other _____

Which program have you participated in? (Mark all that apply)
- ☐ Temporary Assistance (TA)
- ☐ Social Security Disability Insurance
- ☐ Snap
- ☐ Aid to Blind or Totally Disable
- ☐ TANF

- ☐ Yes ☐ No If single, is your documented income below $11,469
- ☐ Yes ☐ No If married, is your family income (you and your spouse) below $21,630
- ☐ Yes ☐ No If married, with 2 additional dependents, is your family income below $32,780

Applicant signature _____

Authorization for Release of Information

(Please PRINT first name, middle initial and last name)

I,_____hereby authorize that information related to my educational record as listed below may be released to federal agencies associated with the grant-funding you are participating with for the purpose of program evaluation and participant tracking.

1. Participant name
2. Social Security number
3. Employment Status
4. Participant telephone number
5. Ethnicity
6. Date of attendance in our program

Student signature: _____

Student Name (please print):_____Date: _____

Processed by:_____Date: _____

This form must be presented to a college official with proper identification.
Please be advised that this authorization will remain in effect for the duration of this grant project until such time that you rescind it in writing.