NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

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

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.**

If you are a **Veteran** with a disability rating of 10% 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
55b/c Program
Albany, NY 12239

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.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

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, 55-c, and Section 50 (3) of the Civil Service Law and Part 58 of 4 NYCRR 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 by the Division of Staffing Services, Department of Civil Service, Albany, New York 12239; telephone (518) 473-6437. 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 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 State of New York to provide for and promote equal opportunity employment, compensation, and other terms and conditions of employment without unlawful discrimination on the basis of age, race, color, creed/religion, disability, national origin, sex/gender, sexual orientation, veteran or military service member status, familial status, marital status, domestic violence victim status, genetic predisposition or carrier status, arrest and/or criminal conviction record, or any other category protected by law, unless based upon a bona fide occupational qualification or other exception.

It is the policy of the New York State Department of Civil Service to provide all qualified persons with equal opportunity in employment and to participate in and receive all the benefits, services, programs and activities of the Department. Reasonable accommodations will be provided to persons with disabilities and those engaged in a religious observance or practice, as are necessary to provide such equal opportunity, including but not limited to, reasonable accommodations in the examination process.

Send Completed Application To:	**New York State Department of Civil Service** **55b/c Program** **Albany, NY 12239**

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 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. Candidates may be requested to provide additional medical documentation to determine eligibility, if needed.

Veterans with a disability rating of 10% or more from the VA may send a copy of your VA Rating Decision Letter in lieu of Form DPM-60. The letter must include both the **rating and the diagnosis** of your disability.

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.

Your 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. Medical information will be kept confidential.

SERVICE IN THE ARMED FORCES OF THE UNITED STATES:				
YES ☐	NO ☐	Do you expect to receive or have you 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 ☐	Are you now serving, or have you 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 until the **Persian Gulf hostilities** end • 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 ☐	Do you have a service connected disability rated at 10% or more by the U.S. Department of Veterans Affairs? This disability must have been incurred during a **Time of War** period listed above.		

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: MO. / YR. From: MO. / YR. To:	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 MO. / YR. From: MO. / YR. To:	FIRM NAME: ADDRESS: CITY AND STATE:
	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 MO. / YR. From: MO. / YR. To:	FIRM NAME: ADDRESS: CITY AND STATE:
	DUTIES:
TYPE OF BUSINESS:	
YOUR EXACT TITLE:	
NAME OF YOUR SUPERVISOR:	
SUPERVISOR'S TITLE:	
No. of hours worked per week: (exclusive of overtime:	

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Albany, NY 12239

STAFFING SERVICES DIVISION

55-b/c Program Physician's Questionnaire

DPM-60 (8/18 L)

Please have your Physician complete this Questionnaire.

This form must be submitted within 180 days from when your physician signs and dates it. In some cases, you may need to attach additional documentation.

If you have questions or concerns, the Office of Employee Health Services 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, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activities also include major bodily functions such as immune system functions, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, and endocrine functions. If there are other life activities, which the applicant's disabilities limit, please note.)	
_____ Physician's Signature	Date: _____