

**TOWN OF GUILDERLAND POLICE DEPARTMENT**

**Guilderland Town Hall**

Route 20

Guilderland, NY 12084

(518) 356-1980



**PRE-EMPLOYMENT PERSONAL  
HISTORY STATEMENT FOR POLICE  
OFFICER CANDIDATES**

All information contained within is confidential.

## **RECRUITMENT, SELECTION, AND APPOINTMENT**

### **Purpose:**

The purpose of this policy is to ensure that qualified candidates are selected for hiring as Guilderland Police Officers and that the selection process is valid, job-related, non-discriminatory, and appropriately documented.

### **Policy:**

It is the policy of the Guilderland Police Department to recruit and select candidates for the position of police officer in accordance with the New York State Civil Service Law, as administered by the Albany County Civil Service Commission, and to afford equal employment opportunity to all eligible candidates. To be eligible for appointment, candidates must meet the prescribed standards set forth by the New York State Bureau for Municipal Police and the Albany County Civil Service Commission. In cases of lateral transfers, only candidates from competitive civil service agencies will be considered for appointment to the Guilderland Police Department. It shall be the responsibility of the Chief of Police to coordinate selection activities.

### **Method:**

#### **A. Recruitment**

Recruitment is the first step in the hiring process. The primary method of recruitment for the position of police officer within the Guilderland Police Department is through the Albany County Civil Service Commission's continuous recruitment testing program.

Candidates considered for appointment to the Guilderland Police Department must be of good moral character and must satisfy the physical fitness requirements prescribed by the New York State Bureau for Municipal Police (B.M.P.) pursuant to §840 of the New York State Executive Law.

#### **B. Oral Interview**

Candidates meeting all the requirements in Section A will be subject to an oral interview by a Town Board member, the Chief of Police, and/or his/her designee(s). Oral interviews will employ a set of questions and the results obtained will be recorded on standardized forms. The recorded results will be kept on file for a minimum of one year after appointment resulting from any series of interviews.

**C. Background Investigations**

All candidates must submit a completed application form. Upon submission of this application and the signing of the standard release form, a thorough background investigation will be conducted. This investigation will include, but is not limited to, investigation of the candidates family, education, residences, work record, physical and emotional health, organizations and affiliations, references, social contacts, credit record, D.M.V. record, military history, county records such as liens and judgments, and criminal history record.

**D. Psychological Screening**

All candidates will be evaluated by a qualified psychologist or psychiatrist to establish a level of emotional stability and psychological fitness compatible with the position of police officer.

**E. Physical Examination**

All candidates will be given a physical examination by a licensed physician in accordance with the standards prescribed by B.M.P.

**F. Physical Agility**

All candidates will be given a physical agility test in accordance with the standards set forth by B.M.P.

**G. Probationary Appointment**

At the conclusion of the selection process, the Chief of Police or his/her designee, will make recommendations to the Guilderland Town Board for the appointments to the position of police officer. All appointments will be probationary for a period of 52 weeks. Subsequent to the effective date of appointment and prior to commencement of official duties, the candidate will be administered the Oath of Officer for Police Officers by the Guilderland Town Supervisor.

**H. Maintenance of Records**

All records of appointed candidates which are not maintained by the Albany County Civil Service Commission shall be maintained by the Guilderland Police Department for six years beyond the duration of employment.

## **PERSONAL HISTORY STATEMENT**

### Instructions:

- This questionnaire must be filled out completely and accurately.
- All responses must be complete, specific, and honest.
- All information provided in the questionnaire is subject to verification and will be used in the background investigation to determine your suitability for the position being sought.
- Incorrect statements may bar or remove you from employment.
- If space provided is inadequate, add another page and identify additional information by item number.
- Type or print, legibly with ink, all responses on this questionnaire.
- Forms or copies of forms to be submitted with your questionnaire are:
  - A recent passport size photograph or yourself
  - Birth certificate
  - Social Security card
  - Driver's license, registrations of all owned vehicles, and proof of insurance for registered vehicles
  - Military DD-214 or other military records
  - Marriage certificate and/or record of divorce – if applicable
  - A copy of your high school diploma or GED
  - Any certification or license showing occupational qualification for the position being sought
- Upon submission of this questionnaire, each page must be initialed by the applicant in the presence of the background investigator indicating that you have provided complete and accurate information.
- Upon submission of this questionnaire, you will be required to sign off on notarized Release of Information forms so that a background investigation can be completed.

**PERSONAL INFORMATION**

Your full name			
Last	First	Middle	
Other names you have used or been known by			
Address of your residence			
Number / Street			Apt #
City		State	Zip
Contact numbers			
Home	Work	Cell	Other
E-mail address(es)			
Are you a citizen of the United States? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Birth place (city / state / country)			
Date of birth		Social Security Number	
		- -	
Driver's License #		Physical Description	
State	Exp.	Hgt	Wgt
		Hair color	Eye color

**RESIDENCES**

<ul style="list-style-type: none"> <li>✓ List all residences during the last 15 years or since your tenth birthday.</li> <li>✓ Start with your present address at the top.</li> <li>✓ Do not list P.O. Boxes.</li> </ul>			
Address			
Number / Street			Apt #
City		State	Zip
From	To	If a rental: List rental owner	
		Rental owner contact number	
Names of people you resided with:			

Address			
Number / Street			Apt #
City		State	Zip
From	To	If a rental: List rental owner	
		Rental owner contact number	
Names of people you resided with:			

Address			
Number / Street			Apt #
City		State	Zip
From	To	If a rental: List rental owner	
		Rental owner contact number	
Names of people you resided with:			

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RESIDENCES (continued)			
Address Number / Street		Apt #	
City		State	Zip
From	To	If a rental: List rental owner	
		Rental owner contact number	
Names of people you resided with:			

Address Number / Street		Apt #	
City		State	Zip
From	To	If a rental: List rental owner	
		Rental owner contact number	
Names of people you resided with:			

Address Number / Street		Apt #	
City		State	Zip
From	To	If a rental: List rental owner	
		Rental owner contact number	
Names of people you resided with:			

Address Number / Street		Apt #	
City		State	Zip
From	To	If a rental: List rental owner	
		Rental owner contact number	
Names of people you resided with:			

Address Number / Street		Apt #	
City		State	Zip
From	To	If a rental: List rental owner	
		Rental owner contact number	
Names of people you resided with:			

\*If additional room is needed, check the box below and list on a blank sheet of paper.

Additional sheets attached

<b>FAMILY HISTORY</b>
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✓ If a category is not applicable, check the box for N/A
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<input type="checkbox"/> N/A	<b>FATHER</b>
	Name <span style="float: right;"><input type="checkbox"/> Check if deceased</span>
Address	Number / Street <span style="float: right;">Apt #</span>
City	State <span style="float: right;">Zip</span>
Contact numbers	Home <span style="margin-left: 100px;">Work</span> <span style="margin-left: 100px;">Cell</span> <span style="margin-left: 100px;">Other</span>
E-mail address(es)	

<input type="checkbox"/> N/A	<b>MOTHER</b>
	Name <span style="float: right;"><input type="checkbox"/> Check if deceased</span>
Address	Number / Street <span style="float: right;">Apt #</span>
City	State <span style="float: right;">Zip</span>
Contact numbers	Home <span style="margin-left: 100px;">Work</span> <span style="margin-left: 100px;">Cell</span> <span style="margin-left: 100px;">Other</span>
E-mail address(es)	

<input type="checkbox"/> N/A	<b>STEP-FATHER</b>
	Name <span style="float: right;"><input type="checkbox"/> Check if deceased</span>
Address	Number / Street <span style="float: right;">Apt #</span>
City	State <span style="float: right;">Zip</span>
Contact numbers	Home <span style="margin-left: 100px;">Work</span> <span style="margin-left: 100px;">Cell</span> <span style="margin-left: 100px;">Other</span>
E-mail address(es)	

<input type="checkbox"/> N/A	<b>STEP-MOTHER</b>
	Name <span style="float: right;"><input type="checkbox"/> Check if deceased</span>
Address	Number / Street <span style="float: right;">Apt #</span>
City	State <span style="float: right;">Zip</span>
Contact numbers	Home <span style="margin-left: 100px;">Work</span> <span style="margin-left: 100px;">Cell</span> <span style="margin-left: 100px;">Other</span>
E-mail address(es)	

<b>FAMILY HISTORY (continued)</b>
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<input type="checkbox"/> N/A	<b>SPOUSE / DOMESTIC PARTNER</b>		
	Name		<input type="checkbox"/> Check if deceased
Address			
	Number / Street		Apt #
	City	State	Zip
Contact numbers			
	Home	Work	Cell Other
E-mail address(es)			
Years of marriage	Are there any current or expired Orders of Protection between you and this individual?		

<input type="checkbox"/> N/A	<b>FATHER-IN-LAW</b>		
	Name		<input type="checkbox"/> Check if deceased
Address			
	Number / Street		Apt #
	City	State	Zip
Contact numbers			
	Home	Work	Cell Other
E-mail address(es)			

<input type="checkbox"/> N/A	<b>MOTHER-IN-LAW</b>		
	Name		<input type="checkbox"/> Check if deceased
Address			
	Number / Street		Apt #
	City	State	Zip
Contact numbers			
	Home	Work	Cell Other
E-mail address(es)			

<input type="checkbox"/> N/A	<b>FORMER SPOUSE(S) / DOMESTIC PARTNER(S) – <i>Not dating partners</i></b>		
	Name		<input type="checkbox"/> Check if deceased
Address			
	Number / Street		Apt #
	City	State	Zip
Contact numbers			
	Home	Work	Cell Other
E-mail address(es)			
Years of marriage	Are there any current or expired Orders of Protection between you and this individual?		

<b>FAMILY HISTORY (continued)</b>
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<input type="checkbox"/> N/A	<b>FORMER SPOUSE(S) / DOMESTIC PARTNER(S) – <i>Not dating partners</i></b>		
	Name	<input type="checkbox"/> Check if deceased	
Address			
	Number / Street	Apt #	
	City	State	Zip
Contact numbers			
	Home	Work	Cell      Other
E-mail address(es)			
	Years of marriage	Are there any current or expired Orders of Protection between you and this individual?	

<input type="checkbox"/> N/A	<b>BROTHERS AND SISTERS – include step-siblings, half-siblings, and foster siblings</b>		
	Name	<input type="checkbox"/> Check if deceased	
Address			
	Number / Street	Apt #	
	City	State	Zip
Contact numbers			
	Home	Work	Cell      Other
E-mail address(es)		Relationship	

	Name	<input type="checkbox"/> Check if deceased	
Address			
	Number / Street	Apt #	
	City	State	Zip
Contact numbers			
	Home	Work	Cell      Other
E-mail address(es)		Relationship	

	Name	<input type="checkbox"/> Check if deceased	
Address			
	Number / Street	Apt #	
	City	State	Zip
Contact numbers			
	Home	Work	Cell      Other
E-mail address(es)		Relationship	

	Name	<input type="checkbox"/> Check if deceased	
Address			
	Number / Street	Apt #	
	City	State	Zip
Contact numbers			
	Home	Work	Cell      Other
E-mail address(es)		Relationship	

\*If additional room is needed, check the box below and list on a blank sheet of paper.

Additional sheets attached

**FAMILY HISTORY (continued)**

**CHILDREN -** include all natural children, adopted children, step children, foster children and any other children who reside with you.

	Name	Age	<input type="checkbox"/> M <input type="checkbox"/> F
Custodial parent / guardian (if other than you)		Contact number	
Address Number / Street <span style="float: right;">Apt #</span>			
City		State	Zip
	Name	Age	<input type="checkbox"/> M <input type="checkbox"/> F
Custodial parent / guardian (if other than you)		Contact number	
Address Number / Street <span style="float: right;">Apt #</span>			
City		State	Zip
	Name	Age	<input type="checkbox"/> M <input type="checkbox"/> F
Custodial parent / guardian (if other than you)		Contact number	
Address Number / Street <span style="float: right;">Apt #</span>			
City		State	Zip
	Name	Age	<input type="checkbox"/> M <input type="checkbox"/> F
Custodial parent / guardian (if other than you)		Contact number	
Address Number / Street <span style="float: right;">Apt #</span>			
City		State	Zip
	Name	Age	<input type="checkbox"/> M <input type="checkbox"/> F
Custodial parent / guardian (if other than you)		Contact number	
Address Number / Street <span style="float: right;">Apt #</span>			
City		State	Zip
	Name	Age	<input type="checkbox"/> M <input type="checkbox"/> F
Custodial parent / guardian (if other than you)		Contact number	
Address Number / Street <span style="float: right;">Apt #</span>			
City		State	Zip

Upon completion, initial each page indicating you have read the page and supplied complete and accurate information \_\_\_\_\_

**PREVIOUS DATING PARTNERS**

List at least four previous dating partners starting with the most recent

	Name		<input type="checkbox"/> Check if deceased
Address			
Number / Street		Apt #	
City		State	Zip
Contact numbers			
Home	Work	Cell	Other
E-mail address(es)			
Are there any current or expired Orders of Protection between you and this individual?			
Length of relationship: (including dates)			

	Name		<input type="checkbox"/> Check if deceased
Address			
Number / Street		Apt #	
City		State	Zip
Contact numbers			
Home	Work	Cell	Other
E-mail address(es)			
Are there any current or expired Orders of Protection between you and this individual?			
Length of relationship: (including dates)			

	Name		<input type="checkbox"/> Check if deceased
Address			
Number / Street		Apt #	
City		State	Zip
Contact numbers			
Home	Work	Cell	Other
E-mail address(es)			
Are there any current or expired Orders of Protection between you and this individual?			
Length of relationship: (including dates)			

	Name		<input type="checkbox"/> Check if deceased
Address			
Number / Street		Apt #	
City		State	Zip
Contact numbers			
Home	Work	Cell	Other
E-mail address(es)			
Are there any current or expired Orders of Protection between you and this individual?			
Length of relationship: (including dates)			

<b>REFERENCES</b>
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List at least five personal references that are not related to your and not former employers, who have known you for at least five years. All persons to whom you refer may be asked to appraise your character, ability, experience, personality, and other qualities.

Name	Occupation
Address Number / Street <span style="float: right;">Apt #</span>	
City <span style="float: right;">State</span> <span style="float: right;">Zip</span>	
Contact numbers Home <span style="margin-left: 100px;">Work</span> <span style="margin-left: 100px;">Cell</span> <span style="margin-left: 100px;">Other</span>	
E-mail address(es)	Years known

Name	Occupation
Address Number / Street <span style="float: right;">Apt #</span>	
City <span style="float: right;">State</span> <span style="float: right;">Zip</span>	
Contact numbers Home <span style="margin-left: 100px;">Work</span> <span style="margin-left: 100px;">Cell</span> <span style="margin-left: 100px;">Other</span>	
E-mail address(es)	Years known

Name	Occupation
Address Number / Street <span style="float: right;">Apt #</span>	
City <span style="float: right;">State</span> <span style="float: right;">Zip</span>	
Contact numbers Home <span style="margin-left: 100px;">Work</span> <span style="margin-left: 100px;">Cell</span> <span style="margin-left: 100px;">Other</span>	
E-mail address(es)	Years known

Name	Occupation
Address Number / Street <span style="float: right;">Apt #</span>	
City <span style="float: right;">State</span> <span style="float: right;">Zip</span>	
Contact numbers Home <span style="margin-left: 100px;">Work</span> <span style="margin-left: 100px;">Cell</span> <span style="margin-left: 100px;">Other</span>	
E-mail address(es)	Years known

Name	Occupation
Address Number / Street <span style="float: right;">Apt #</span>	
City <span style="float: right;">State</span> <span style="float: right;">Zip</span>	
Contact numbers Home <span style="margin-left: 100px;">Work</span> <span style="margin-left: 100px;">Cell</span> <span style="margin-left: 100px;">Other</span>	
E-mail address(es)	Years known

<b>AQUAINTANCES</b>
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List at least four persons that are not related to your and not former employers or references, who are friends, fellow students or fellow workers. Names should be those of persons who have seen you frequently during the past year.

Name	Occupation
Address Number / Street <span style="float: right;">Apt #</span>	
City <span style="float: right;">State</span> <span style="float: right;">Zip</span>	
Contact numbers Home <span style="margin-left: 100px;">Work</span> <span style="margin-left: 100px;">Cell</span> <span style="margin-left: 100px;">Other</span>	
E-mail address(es)	Years known
In what capacity is this person known to you?	

Name	Occupation
Address Number / Street <span style="float: right;">Apt #</span>	
City <span style="float: right;">State</span> <span style="float: right;">Zip</span>	
Contact numbers Home <span style="margin-left: 100px;">Work</span> <span style="margin-left: 100px;">Cell</span> <span style="margin-left: 100px;">Other</span>	
E-mail address(es)	Years known
In what capacity is this person known to you?	

Name	Occupation
Address Number / Street <span style="float: right;">Apt #</span>	
City <span style="float: right;">State</span> <span style="float: right;">Zip</span>	
Contact numbers Home <span style="margin-left: 100px;">Work</span> <span style="margin-left: 100px;">Cell</span> <span style="margin-left: 100px;">Other</span>	
E-mail address(es)	Years known
In what capacity is this person known to you?	

Name	Occupation
Address Number / Street <span style="float: right;">Apt #</span>	
City <span style="float: right;">State</span> <span style="float: right;">Zip</span>	
Contact numbers Home <span style="margin-left: 100px;">Work</span> <span style="margin-left: 100px;">Cell</span> <span style="margin-left: 100px;">Other</span>	
E-mail address(es)	Years known
In what capacity is this person known to you?	

<b>EDUCATION</b>
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You may be asked to furnish transcripts or other proof of education

<b>Grammar Schools</b>		
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Name	City	State
From	To	

Name	City	State
From	To	

<b>High Schools</b>		
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Name	City	State
From	To	Did you graduate? <input type="checkbox"/> YES <input type="checkbox"/> NO* <span style="float: right;">*If NO, explain below</span>
*Explain:		

Name	City	State
From	To	Did you graduate? <input type="checkbox"/> YES <input type="checkbox"/> NO* <span style="float: right;">*If NO, explain below</span>
*Explain:		

<b>Colleges or Universities</b>			
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<input type="checkbox"/> N/A	Name	City	State
From	To	Did you graduate? <input type="checkbox"/> YES <input type="checkbox"/> NO <span style="float: right;">*If YES, list type of degree below</span>	
Type of degree		Number of credits earned	

<input type="checkbox"/> N/A	Name	City	State
From	To	Did you graduate? <input type="checkbox"/> YES <input type="checkbox"/> NO <span style="float: right;">*If YES, list type of degree below</span>	
Type of degree		Number of credits earned	

<input type="checkbox"/> N/A	Name	City	State
From	To	Did you graduate? <input type="checkbox"/> YES <input type="checkbox"/> NO <span style="float: right;">*If YES, list type of degree below</span>	
Type of degree		Number of credits earned	

<input type="checkbox"/> N/A	Name	City	State
From	To	Did you graduate? <input type="checkbox"/> YES <input type="checkbox"/> NO <span style="float: right;">*If YES, list type of degree below</span>	
Type of degree		Number of credits earned	

**EDUCATION (continued)**

**Trade Schools, Vocational Training, or Business Schools / Institutes**

<input type="checkbox"/> N/A	Name	City	State
From	To	Course completed?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Type of school or training			

<input type="checkbox"/> N/A	Name	City	State
From	To	Course completed?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Type of school or training			

<input type="checkbox"/> N/A	Name	City	State
From	To	Course completed?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Type of school or training			

**Basic Police Academy**

You may need to provide any certificates or other proof of successful completion.

<input type="checkbox"/> N/A	Name	City	State
From	To	Did you graduate?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Academy Director		Contact number	

<input type="checkbox"/> N/A	Name	City	State
From	To	Did you graduate?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Academy Director		Contact number	

**Police Training**

List any additional police related training courses / programs you have successfully completed.  
You may need to provide certificates of completion or other proof of successful completion of the training.

<input type="checkbox"/> N/A	Course	Location of training	Date(s)
<input type="checkbox"/> N/A	Course	Location of training	Date(s)
<input type="checkbox"/> N/A	Course	Location of training	Date(s)
<input type="checkbox"/> N/A	Course	Location of training	Date(s)
<input type="checkbox"/> N/A	Course	Location of training	Date(s)
<input type="checkbox"/> N/A	Course	Location of training	Date(s)
<input type="checkbox"/> N/A	Course	Location of training	Date(s)
<input type="checkbox"/> N/A	Course	Location of training	Date(s)

**EDUCATION (continued)**

Were you ever suspended, expelled, placed on academic discipline or ever disciplined by any school?  
 YES – if so explain below  
 NO

Explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MILITARY**

N/A      Check the box to the left if you have never served in the United State military and skip to the next section  
 Starting with the most recent assignment, list all United States military experience  
 A copy of your DD-214 may be requested for verification of service and/or discharge

Branch	Rank	Job Title
From	To	Commanding Officer

Branch	Rank	Job Title
From	To	Commanding Officer

Was there ever any disciplinary action taken against you while in the military?       YES – If yes, explain below  
 NO

Explain:

\_\_\_\_\_

\_\_\_\_\_

List all medals and decorations awarded to you as a member of the United States military:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was there ever any disciplinary action taken against you while in the military?       YES – If yes, explain below  
 NO

Explain:

\_\_\_\_\_

\_\_\_\_\_

List type of discharge:

\_\_\_\_\_

Are you or were you a member of the United States Reserve Forces or the National Guard?       YES – If yes, explain below  
 NO

Branch / State	From	To	Type of Discharge
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**WORK HISTORY**

Starting with your current or most recent job, list all jobs you have had.  
List all periods of unemployment between jobs.

Name of employer		Job title / Position		
Address Number / Street <span style="float: right;">Apt #</span>				
City		State		Zip
Supervisor		Contact number	Extension	
From	To	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Self employed <input type="checkbox"/> Volunteer	<input type="checkbox"/> Temporary
Duties / Assignments				
Names of co-workers 1)		2)	3)	
Reason for leaving			Weekly salary	

Period of unemployment Reason:	From	To
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Name of employer		Job title / Position		
Address Number / Street <span style="float: right;">Apt #</span>				
City		State		Zip
Supervisor		Contact number	Extension	
From	To	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Self employed <input type="checkbox"/> Volunteer	<input type="checkbox"/> Temporary
Duties / Assignments				
Names of co-workers 1)		2)	3)	
Reason for leaving			Weekly salary	

Period of unemployment Reason:	From	To
-----------------------------------	------	----

Name of employer		Job title / Position		
Address Number / Street <span style="float: right;">Apt #</span>				
City		State		Zip
Supervisor		Contact number	Extension	
From	To	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Self employed <input type="checkbox"/> Volunteer	<input type="checkbox"/> Temporary
Duties / Assignments				
Names of co-workers 1)		2)	3)	
Reason for leaving			Weekly salary	

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**WORK HISTORY (continued)**

Period of unemployment Reason:	From	To
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Name of employer		Job title / Position	
Address Number / Street <span style="float: right;">Apt #</span>			
City		State	Zip
Supervisor		Contact number	Extension
From	To	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Self employed <input type="checkbox"/> Volunteer
<input type="checkbox"/> Temporary			
Duties / Assignments			
Names of co-workers 1)		2)	3)
Reason for leaving		Weekly salary	

Period of unemployment Reason:	From	To
-----------------------------------	------	----

Name of employer		Job title / Position	
Address Number / Street <span style="float: right;">Apt #</span>			
City		State	Zip
Supervisor		Contact number	Extension
From	To	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Self employed <input type="checkbox"/> Volunteer
<input type="checkbox"/> Temporary			
Duties / Assignments			
Names of co-workers 1)		2)	3)
Reason for leaving		Weekly salary	

Period of unemployment Reason:	From	To
-----------------------------------	------	----

Name of employer		Job title / Position	
Address Number / Street <span style="float: right;">Apt #</span>			
City		State	Zip
Supervisor		Contact number	Extension
From	To	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Self employed <input type="checkbox"/> Volunteer
<input type="checkbox"/> Temporary			
Duties / Assignments			
Names of co-workers 1)		2)	3)
Reason for leaving		Weekly salary	

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**WORK HISTORY (continued)**

Period of unemployment Reason:	From	To
-----------------------------------	------	----

Name of employer		Job title / Position		
Address Number / Street <span style="float: right;">Apt #</span>				
City		State		Zip
Supervisor		Contact number	Extension	
From	To	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Self employed <input type="checkbox"/> Volunteer	<input type="checkbox"/> Temporary
Duties / Assignments				
Names of co-workers 1)		2)	3)	
Reason for leaving			Weekly salary	

Period of unemployment Reason:	From	To
-----------------------------------	------	----

Name of employer		Job title / Position		
Address Number / Street <span style="float: right;">Apt #</span>				
City		State		Zip
Supervisor		Contact number	Extension	
From	To	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Self employed <input type="checkbox"/> Volunteer	<input type="checkbox"/> Temporary
Duties / Assignments				
Names of co-workers 1)		2)	3)	
Reason for leaving			Weekly salary	

Period of unemployment Reason:	From	To
-----------------------------------	------	----

Name of employer		Job title / Position		
Address Number / Street <span style="float: right;">Apt #</span>				
City		State		Zip
Supervisor		Contact number	Extension	
From	To	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	<input type="checkbox"/> Self employed <input type="checkbox"/> Volunteer	<input type="checkbox"/> Temporary
Duties / Assignments				
Names of co-workers 1)		2)	3)	
Reason for leaving			Weekly salary	

**WORK HISTORY (continued)**

Are you now or have you ever been engaged in any business as an owner, partner, or corporate member?	<input type="checkbox"/> YES – If yes, explain below <input type="checkbox"/> NO
Explain:  <hr/> <hr/>	

Have you ever been disciplined at work? (Including written warnings, letters on counseling, reprimands, suspensions, reductions in pay, reassignments or demotions)	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

Have you ever been fired, released during a probationary period or asked to resign from a job?	<input type="checkbox"/> YES <input type="checkbox"/> NO
--	---

Were you ever involved in a physical / verbal altercation with a co-worker, supervisor or anyone at work?	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

Have you ever quit without giving proper notice to your employer?	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

Have you ever resigned from a position in lieu of being terminated?	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

Has a co-worker, supervisor, subordinate, or customer ever accused you of discrimination? (e.g. sexual harassment, racial bias, sexual orientation, etc.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

Have you ever been the subject of a written complaint at work?	<input type="checkbox"/> YES <input type="checkbox"/> NO
--	---

Have you ever been counseled at work due to lateness or absences?	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

Have you ever received an unsatisfactory performance review?	<input type="checkbox"/> YES <input type="checkbox"/> NO
--	---

Have you ever sold, released, or given away legally confidential information?	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

Have you ever called in sick when you were not sick nor were not caring for a sick family member?	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

Have you ever filed a claim for worker's compensation?	<input type="checkbox"/> YES <input type="checkbox"/> NO
--	---

In the past five years, have you ever missed any days or been to work due to drug or alcohol consumption?	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

Has your work performance ever been affected by your use of alcohol or drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

In the past five years, have you been warned by an employer about the impact	<input type="checkbox"/> YES <input type="checkbox"/> NO
--	---

If you answered 'YES' to any of the above questions on this page, explain below:  <hr/> <hr/> <hr/>
---

**WORK HISTORY (continued)**

Have you ever applied with the Guilderland Police Department?	<input type="checkbox"/> YES – If yes, explain below <input type="checkbox"/> NO
If YES, list the approximate date the application(s) was filed:	

Have you ever applied to any other law enforcement agency?	<input type="checkbox"/> YES – If yes, explain below <input type="checkbox"/> NO
<ul style="list-style-type: none"> <li>• If YES, starting with the most recent, list every agency you have applied with</li> </ul>	

Agency Name & Address	
Position Applied For	Date of Application

Agency Name & Address	
Position Applied For	Date of Application

Agency Name & Address	
Position Applied For	Date of Application

Agency Name & Address	
Position Applied For	Date of Application

Agency Name & Address	
Position Applied For	Date of Application

Agency Name & Address	
Position Applied For	Date of Application

Agency Name & Address	
Position Applied For	Date of Application

Agency Name & Address	
Position Applied For	Date of Application

Agency Name & Address	
Position Applied For	Date of Application

Agency Name & Address	
Position Applied For	Date of Application

**FINANCIAL**

Applicants are required to submit a current credit report with this application

List your monthly take home salary from your employer(s) \$ \_\_\_\_\_

List any other monthly income other than from salary or wages \$ \_\_\_\_\_  
\*Explain nature of income below:

\_\_\_\_\_

Estimate your monthly expenses \$ \_\_\_\_\_  
Expenses include: housing, utilities, credit cards, loan payments, food, gas, car maintenance, entertainment, as well as any other expenses

Is your life insured?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES:	Value	Company
-----------------------	---	---------	-------	---------

Do you have a savings account?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES:	Amount	Bank
--------------------------------	---	---------	--------	------

Do you have a checking account?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES:	Amount	Bank
---------------------------------	---	---------	--------	------

Do you own or are you buying your own home?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES:	Amount invested	Bank
---	---	---------	-----------------	------

Do you own or are you buying your own vehicle?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES:	Amount owed	Bank
--	---	---------	-------------	------

Do you own or are you buying other real estate?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES:	Amount invested	Bank
---	---	---------	-----------------	------

Have you ever filed for or declared bankruptcy? (Chapter 7, 11, or 13)	<input type="checkbox"/> YES <input type="checkbox"/> NO
--	---

Have any of your bills ever been turned over to a collection agency?	<input type="checkbox"/> YES <input type="checkbox"/> NO
--	---

Has anything you ever purchased been repossessed?	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

Have your wages ever been garnished?	<input type="checkbox"/> YES <input type="checkbox"/> NO
--------------------------------------	---

Have you ever been delinquent on income or other tax payments?	<input type="checkbox"/> YES <input type="checkbox"/> NO
--	---

Have you ever failed to file or cheated / lied on an income tax form?	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

Have you ever had an employment bond refused?	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

Have you ever avoided paying any lawful debt by moving away?	<input type="checkbox"/> YES <input type="checkbox"/> NO
--	---

Have you ever defaulted on a loan?	<input type="checkbox"/> YES <input type="checkbox"/> NO
------------------------------------	---

Have you ever borrowed money to pay for a gambling debt?	<input type="checkbox"/> YES <input type="checkbox"/> NO
--	---

Have you ever spend money for illegal purposes? (illegal drugs, prostitution, illegal documents, etc)	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

Have you ever failed to make or been late on a court ordered payment? (child support, restitution, etc)	<input type="checkbox"/> YES <input type="checkbox"/> NO
---	---

Have you ever written a bad check?	<input type="checkbox"/> YES <input type="checkbox"/> NO
------------------------------------	---

**FINANCIAL (continued)**

**CREDIT HISTORY**  
List all current credit card / loan accounts which are currently open or have outstanding balances due. This includes student and college loans and private / personal loans.

Company / Bank:	Original amount of loan:
Monthly payment:	Amount outstanding:

Company / Bank:	Original amount of loan:
Monthly payment:	Amount outstanding:

Company / Bank:	Original amount of loan:
Monthly payment:	Amount outstanding:

Company / Bank:	Original amount of loan:
Monthly payment:	Amount outstanding:

Company / Bank:	Original amount of loan:
Monthly payment:	Amount outstanding:

Company / Bank:	Original amount of loan:
Monthly payment:	Amount outstanding:

Company / Bank:	Original amount of loan:
Monthly payment:	Amount outstanding:

Company / Bank:	Original amount of loan:
Monthly payment:	Amount outstanding:

Company / Bank:	Original amount of loan:
Monthly payment:	Amount outstanding:

Company / Bank:	Original amount of loan:
Monthly payment:	Amount outstanding:

Company / Bank:	Original amount of loan:
Monthly payment:	Amount outstanding:

Company / Bank:	Original amount of loan:
Monthly payment:	Amount outstanding:

Company / Bank:	Original amount of loan:
Monthly payment:	Amount outstanding:

**MEDICAL**

Have you ever or do you now have any of the following?  
For "YES" answers, supply complete details in the space at the end of this section.  
If the condition required hospitalization, check the HOSP box.

1. Head injury	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
2. Back trouble or back pain	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
3. Any defect of bones or joints including amputations, dislocations, broken bones, etc	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
4. Lameness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
5. Rheumatism or arthritis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
6. Trick or locked knee injury	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
7. Foot trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
8. Eye injury, surgery, or disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
9. Have you ever worn glasses	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
10. Hard of hearing or hearing problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
11. Worn a hearing aid	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
12. Headaches	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
13. Mental illness, nervous breakdown, or panic attacks	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
14. Addiction to drugs or alcohol	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
15. Fainting or dizzy spells	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
16. Epilepsy or fits	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
17. Any disorder of the nervous system	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
18. Tuberculosis or other lung disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
19. Shortness of breath	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
20. Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
21. Bronchitis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
22. Poison ivy or poison oak	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
23. Skin trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
24. Sensitivity to dust	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
25. Other allergies	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
26. Frequent colds	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
27. Cancer or malignancy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
28. Tumor growth or cyst	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
29. Any complications from childhood diseases	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
30. Polio	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
31. Rheumatic fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
32. Heart trouble including circulatory problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
33. High or low blood pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
34. Varicose veins	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
35. Pernicious anemia, leukemia, or other blood disorder / ailment	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
36. Hepatitis, jaundice, or other liver ailment	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
37. Diabetes or sugar in urine	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP

**MEDICAL (continued)**

38. Ulcers or other stomach trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
39. Colitis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
40. Gall bladder trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
41. Kidney or bladder trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
42. Piles or hemorrhoids	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
43. Rupture or hernia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
44. Mononucleosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
45. Have you ever been advised to have an operation? If YES provide reason(s) and date(s) or operation(s)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
46. Have you ever been a patient (committed or voluntary) in a mental hospital? If YES provide reason(s), date(s), and facility name(s)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> HOSP
47. Have you ever been denied employment or insurance for medical reasons?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
48. Have you ever been deferred from military service for medical, emotional, or health reasons?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
49. Have you ever been discharged or released from employment or from the military for medical, emotional, or health reasons?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
50. Have you ever received or applied for a pension or compensation for disability or injury?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
51. Are you presently under a doctor's care for any condition?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
52. Have you taken medication in the last 12 months for any reason? If YES explain	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
53. Do you have or have you had any physical or emotional limitations? If YES explain	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

For items checked YES, identify the appropriate item number and provide information on the physician that was consulted for the condition:

ITEM	PHYSICIAN'S NAME	ADDRESS

For items checked YES, identify the appropriate item number and provide your own explanation including diagnosis, date of onset, and your present condition. Attach additional sheets if needed.

ITEM	EXPLANATION

**POLICE CONTACT, ARRESTS, AND LEGAL**

Answer all of the following questions completely and accurately. Any falsification or misstatements of fact may be sufficient to disqualify you. (Exclude traffic situations)

Have you ever been arrested, detained for investigation, questioned, fingerprinted, criminally charged, or convicted of any misdemeanor or felony?  YES  NO

**If YES, explain below**

Date	Agency
Reason / Charge	
Disposition	

Date	Agency
Reason / Charge	
Disposition	

Date	Agency
Reason / Charge	
Disposition	

Date	Agency
Reason / Charge	
Disposition	

Date	Agency
Reason / Charge	
Disposition	

Date	Agency
Reason / Charge	
Disposition	

Have you ever been placed on Probation?  YES  NO  
If YES, explain –  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**POLICE CONTACTS, ARRESTS, AND LEGAL (continued)**

Have you ever been reported as a missing person or runaway?  YES  NO  
If YES, explain –  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been a subject involved in a civil lawsuit?  YES  NO  
If YES, explain –  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been a subject of an investigation by Child Protective Services?  YES  NO  
If YES, explain –  
\_\_\_\_\_  
\_\_\_\_\_

Have the police ever responded to your residence for any reason?  YES  NO  
If YES, explain –  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had an Order of Protection (restraining order) issued against you?  YES  NO  
If YES, explain –  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had an Order of Protection (restraining order) issued against someone?  YES  NO  
If YES, explain –  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever filed a false worker's compensation claim?  YES  NO  
If YES, explain –  
\_\_\_\_\_  
\_\_\_\_\_

This section relates to any current and past recreational drug use. This section relates, but is not limited to, the following drugs:

• Marihuana	• Cocaine / Crack	• Steroids	• Heroin / Opium
• Hashish / Hash Oil	• Hallucinogens (mushrooms, LSD)	• PCP (angel dust)	• Amphetamines (including Meth)
• Barbiturates	• Morphine	• Quaaludes	• Ecstasy
• Inhalants (glue)	• GHB	• Steroids	• Prescription pills

Have you ever used any of the drugs listed above? (exclude if prescribed by a doctor)  YES  NO  
If YES, explain in detail including what was used, how often it was used, last time used, and circumstances under which it was used –  
\_\_\_\_\_  
\_\_\_\_\_

**DRIVER'S LICENSE AND MOTOR VEHICLES**

Current Driver's License #	State	Exp.	Exact Name On License:
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Have you ever been had a driver's license in another state?  YES  NO  
 If YES, indicate which state, driver's license number and name which appeared on license –

---



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Has your driver's license ever been suspended or revoked?  YES  NO  
 If YES, explain when, where, and why –

---



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Have you ever been refused a driver's license by any state?  YES  NO  
 If YES, explain when, where, and why –

---



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**List all motor vehicles currently registered to you or your family in your household:**

Plate #	State:	Make:	Model:	Color:
Insurance Company:				

Plate #	State:	Make:	Model:	Color:
Insurance Company:				

Plate #	State:	Make:	Model:	Color:
Insurance Company:				

Plate #	State:	Make:	Model:	Color:
Insurance Company:				

**List all traffic citations you have received:**

DATE	LOCATION	NATURE OF VIOLATION	DISPOSITION / PENALTY

**DRIVER'S LICENSE AND MOTOR VEHICLES (continued)**

List all traffic accidents you have been involved in:

Date	Location	Cause	
<input type="checkbox"/> Injury	<input type="checkbox"/> Property Damage	Police Report? <input type="checkbox"/> Yes <input type="checkbox"/> No	Investigating Police Agency:

Date	Location	Cause	
<input type="checkbox"/> Injury	<input type="checkbox"/> Property Damage	Police Report? <input type="checkbox"/> Yes <input type="checkbox"/> No	Investigating Police Agency:

Date	Location	Cause	
<input type="checkbox"/> Injury	<input type="checkbox"/> Property Damage	Police Report? <input type="checkbox"/> Yes <input type="checkbox"/> No	Investigating Police Agency:

Date	Location	Cause	
<input type="checkbox"/> Injury	<input type="checkbox"/> Property Damage	Police Report? <input type="checkbox"/> Yes <input type="checkbox"/> No	Investigating Police Agency:

Date	Location	Cause	
<input type="checkbox"/> Injury	<input type="checkbox"/> Property Damage	Police Report? <input type="checkbox"/> Yes <input type="checkbox"/> No	Investigating Police Agency:

**MISCELLANEOUS TOPICS**

Do you drink alcoholic beverages?  YES    NO  
 If YES, indicate to what degree –  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever been involved in a physical fight, confrontation, or other incident involving violence? (exclude incidents involving job related incidents as a police officer)  YES    NO  
 If YES, explain when and circumstances –  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever been involved in an act of domestic violence involving your spouse or romantic partner?  YES    NO  
 If YES, explain with whom, when, and circumstances –  
 \_\_\_\_\_  
 \_\_\_\_\_

**MISCELLANEOUS TOPICS (continued)**

Have you ever been or are you currently associated with or involved in any criminal organization, street gang, or any group that advocates violence against people because of their race, religion, ethnicity, nationality, gender, sexual preference, disability, or political affiliation?  YES  NO  
If YES, explain –  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a pistol permit?  YES  NO  
If YES,  
State / County issued: \_\_\_\_\_ Permit # \_\_\_\_\_  
Issuing Judge \_\_\_\_\_ Court Issued: \_\_\_\_\_  
Type of Permit (conceal & carry, target, etc.) \_\_\_\_\_

Do you own any firearms?  YES  NO  
If YES, list types of firearms –  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything else in your background that has not been asked that, if discovered during the course of a background investigation, may be embarrassing to you and / or this agency?  YES  NO  
If YES, explain –  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything else in your background that has not been asked that this agency should be aware of?  YES  NO  
If YES, explain –  
\_\_\_\_\_  
\_\_\_\_\_

If it became necessary in the course of police duties to take a human life, would you have any reluctance to do so because of a religious or other beliefs?  YES  NO  
If YES, explain –  
\_\_\_\_\_  
\_\_\_\_\_

