Wyckoff Heights Medical Center
374 Stockholm Street, Brooklyn NY 11237
Phone (718) 963-7711, Fax (718) 963-6796

Applications Instructions:

Thank you for your interest in the Pediatric Nurse Practitioner Fellowship program at Wyckoff Heights Medical Center. Please complete the application below and include all additional requirements as listed in the checklist. All material can be submitted to NPFellowship@wyckoffhospital.org or mailed in to the address below. Letters of recommendation and application fee may be submitted separately. Please contact Rachel McKenny, CPNP with any questions. Her contact information is:

Rachel McKenny, CPNP
1411 Myrtle Avenue
Brooklyn, NY 11237
718-963-7368
rmckenny@wyckoffhospital.org

Please notify Ms. McKenny via email or phone call when your application has been submitted. You will receive a confirmatory email once your completed application has been received. If you do not receive this email, please call Ms. McKenny to notify her so we can ensure no emailed applications are sent to spam folder.

Applicants will be invited to interview starting in April 2024.

Wyckoff Heights Medical Center
374 Stockholm Street, Brooklyn, NY 11237
Phone (718) 963-7711, Fax (718) 417-5783

APPLICATION FOR EMPLOYMENT

AS AN EQUAL OPPORTUNITY EMPLOYER, WE ACTIVELY SUPPORT ALL APPLICABLE FEDERAL, STATE, AND LOCAL LAWS PROHIBITING DISCRIMINATION IN EMPLOYMENT

Date: _____
Position Applied for: _____ Salary Desired: _____
Will you accept another position? Yes__ No__ If yes, please specify: _____
Please note all Shifts/Hours available to work Sunday – Saturday: _____

PERSONAL HISTORY

Last Name	First	Middle	Social Security Number
			- -

Street Address	Apt. No.	City	State	Zip Code

Home Phone Number	Email	Introduced to Wyckoff Heights Medical Center by:
( ) -		

Have you ever worked under any other name?
YES__ NO__ If YES, please indicate name and employer:

Have you ever been employed by or volunteered at WYCKOFF HEIGHTS MEDICAL CENTER?
YES__ NO__ If YES, please indicate: From_____ To_____ Department _____
Reason for leaving:

Are you over 18 years of age?
YES__ NO__ If NO, state your age and Working Papers Number:

Are you related to anyone employed by WYCKOFF HEIGHTS MEDICAL CENTER?
YES__ NO__ If YES, give details:

Have you ever applied for a position with WYCKOFF HEIGHTS MEDICAL CENTER?
YES__ NO__ If YES, give details:

Are you either a U.S Citizen or an Alien who is legally authorized to work in the U.S?
YES__ NO__ As a condition of employment you must complete an I-9 form required by the Immigration and Naturalization Service no later than three (3) business days after your date of hire.

Have you been subject of any adverse action(s) by any duly authorized sanctioning or disciplinary agency for either conduct-based or performance-based actions? YES__ NO__
If yes, explain: _____
_____
_____

All employees are obligated to inform Wyckoff Heights Medical Center if and when they become aware of any investigation or action by any federal or state sanction or disciplinary agency or if they are excluded from any government payer program.

Initials: _____

PROFESSIONAL LICENSES, CERTIFICATIONS, PERMITS

New York State License Number:_____ Expiration Date:_____ Licensed & Registered in any other state? YES__ NO__
License Number: _____ Expiration Date: _____
Professional Organizations:_____
License/Certification Number:_____ Expiration Date:_____
Certification Designation (RD, RRA, RRT, ASCP, etc.):_____

SKILLS

__Typing Speed:_____ WPM __Steno Speed:_____ WPM __Shorthand:_____ WPM
__Knowledge of Medical Terminology __CRT/Data Entry __Bookkeeping
__Dictaphone __Word Processing __Personal Computer
List any office machines, equipment and software that you can properly operate:_____
_____
Languages spoken: English__ Spanish__ Italian__ French__
Other/Comments:

EDUCATION HISTORY

	Name and Location of School	Dates: From & To	Did you graduate? If so, Degree Completed	GPA	Course of Study
High School					
Trade/Business School					
College/University					
Graduate School					
Other					

PERSONAL REFERENCES (Not Former Employer or Relatives)

Name and Occupation	Address	Phone Number	Relation

BUSINESS REFERENCES (Former Employers or Professionals)

Name and Occupation	Address	Phone Number	Relation

U.S. MILITARY SERVICE

Branch of Service:_____ Final Rank: _____ Dates: From_____ To_____
Specialty: _____
_____

ACADEMIC AND PROFESSIONAL ACTIVITIES AND ACHIEVEMENTS

Academic and professional activities and achievements, awards, publications or technical-professional societies. Indicate type or name. Exclude organizations which may indicate race, creed, color, sex, age, religion, handicap or nation origin or its members. DATE AWARDED:	

EMPLOYMENT AND VOLUNTEER HISTORY- Account for all employment, beginning with your most recent employment.

Organization Name and Address	Employment Dates	Position Held and Description of Duties __F/T __P/T
Employer	Date Hired	
Street Address	Date Separated	
City and State	Zip	Telephone Number ( )
Starting Base Pay	Ending Base Pay	Name and Title of Immediate Supervisor
Reason for Leaving: May we contact them __Yes __No		

Organization Name and Address	Employment Dates	Position Held and Description of Duties __F/T __P/T
Employer	Date Hired	
Street Address	Date Separated	
City and State	Zip	Telephone Number ( )

Starting Base Pay	Ending Base Pay	Name and Title of Immediate Supervisor
Reason for Leaving: May we contact them __Yes __No		

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Starting Base Pay	Ending Base Pay	Name and Title of Immediate Supervisor
Reason for Leaving: May we contact them __Yes __No		

PLEASE READ CAREFULLY BEFORE SIGNING BELOW

I have read and fully understand the questions asked in this application. I certify that all of the information contained in this application is true, accurate and complete to the best of my knowledge and understand that any false, inaccurate or erroneous answers, omissions or statements made by me on this application, during an interview or in any other required documents shall be grounds for denial and/or discharge from employment. I authorize Wyckoff Heights Medical Center to make a thorough investigation including but not limited to my past employment, education, motor vehicle history, military, character, reputation and activities and release from liability all persons, companies or corporations supplying such information. I also agree to indemnify Wyckoff Heights Medical Center against any liability which may result from making such investigation and release all persons from liability for doing so.

If an employment relationship is established, I authorize Wyckoff Heights Medical Center to make a thorough investigation including but not limited to my criminal history and release from liability all persons, companies or corporations supplying such information.

If an employment relationship is established, I agree to notify Wyckoff Heights Medical Center in writing within five (5) days of receiving any written or oral notice of any adverse action, including, without limitation, exclusion from participation in any federal or state health care or procurement programs; any filed and served malpractice suit or arbitration action; any adverse action by a State Licensing Board taken or pending; any adverse action which has resulted in the filing of a report with the State Licensing Board; any revocation of DEA license; a conviction of any felony or a misdemeanor of moral turpitude; any action against any certification under the Medicare or Medicaid programs; or any cancellation, non-renewal or material reduction in medical liability insurance policy coverage.

I agree to notify Wyckoff Heights Medical Center in writing within five (5) days of receiving any written or oral notice of investigation that may result in adverse action by any duly authorized regulatory or enforcement agency of the State of New York or Federal Government.

I understand that any offer of employment is subject to satisfactory completion of a medical examination, which may include drug and alcohol screening that can be required as a condition of continued employment. I further understand that Wyckoff Heights Medical Center is committed to maintaining a "substance abuse free" environment for all of its employees and that should the pre-employment medical evaluation reveal the presence of an illegal drug, misuse or abuse of a controlled substance or other substance which may alter or impair my behavior and/or ability to function, I will not be employed.

I understand that if an employment relationship is established, it shall not be for a definite period and my employment can be terminated, for any reason or no reason at all, with or without notice, at any time, at the option of either Wyckoff Heights Medical Center or myself. I also agree that in the event of my employment with Wyckoff Heights Medical center, I shall abide by all present and subsequent rules and regulations of Wyckoff Heights Medical Center.

_____ _____

Signature of Applicant Date

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Final Checklist

[ ] Fellowship application

[ ] CV with graduate clinical rotations

[ ] Copy of current transcripts

[ ] Copy of New York State Registered Nurse and Pediatric Nurse Practitioner license

- Please put N/A if not graduated from PNP program yet

[ ] Personal Statement

[ ] 3 letters of recommendation

- Dated, signed and addressed to Rachel McKenny, CPNP (can be included in packet or sent separately)
- One from NP Program Director
- One from NP Clinical Preceptor
- One from previous supervisor or other NP Clinical Preceptor

[ ] Copy of current BLS, PALS, ACLS, etc certification

[ ] 2 passport sized photos

[ ] $25 application fee – make check payable to Wyckoff Heights Medical Center

- Please write PNP Fellowship in the memo section of check