

## CUSTOMER REGISTRATION FORM

Date: \_\_\_\_\_

### I. GENERAL INFORMATION

Social Security # _____	Last Name _____	First Name _____	M.I. _____
Street Address _____	City _____	State _____	Zip _____
County _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
*Date of Birth (Proof must be shown - driver's license, passport, NYS ID card, or DHS Benefit Card) _____			

How do you prefer to be contacted? (Check all that apply)

Mail     
  Primary Phone \_\_\_\_\_     
  Alternate Phone \_\_\_\_\_  
 Fax Number \_\_\_\_\_     
  E-Mail \_\_\_\_\_

Are you registered with Selective Service?  Yes  No     
 Are you a US Citizen?  Yes  No  
 (Males born on or after January 1, 1960)     
 If not, are you authorized to work in the US?  Yes  No  
 If No, did you willfully avoid registration?  Yes  No

Ethnicity:     
  White (not Hispanic)     
  Black, or African American     
  Hispanic or Latino  
 Alaskan/American Indian     
  Asian (not Hispanic)     
  Hawaiian/Pacific Islander     
 Other

### II. Education

Are you attending a secondary, vocational, technical or academic school full-time? (12 hrs. or more)  Yes  No  
 If you are between terms, do you intend to return to school?  Yes  No

Education/Training: (check highest level completed):  Less than High School     
  High School Diploma or GED  
 Some College   
 Licensed   
 Certification

Name of Issuing Organization	Date of Issue
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Vocational Degree   
 Associates Degree   
 Bachelor's Degree   
 Master's Degree   
 Doctoral Degree

Name of College or University & Location	Course of Study	Date of Issue
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Grade: (Circle highest level)

No Grade    1    2    3    4    5    6    7    8    9    10    11   
 or Disabled with Certificate/IEP     
 GED     
 HS Graduate

High School +:     
 1 year     
 2 years     
 3 years college or voc/tech     
 Bachelor's or equivalent

Are You:   
 Employed? Or   
 Unemployed?     
 Number of Weeks Not Employed \_\_\_\_\_

### III. ADDITIONAL INFORMATION

What is your disability status?   
 Disabled   
 Not Disabled     
 Are you a migrant/seasonal worker?  Yes  No

Are you or any member of your household receiving PA?  Yes  No   
 TANF?  Yes  No   
 Safety Net?  Yes  No

Food Stamps or Other Income Support?  Yes  No     
 Are you participating in the Jobs Program?  Yes  No

Are you a Veteran?  Yes  No     
 Dates of Active Service \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you receiving compensation for a service-connected disability?   
 Yes  No   
 If yes, list% of disability: \_\_\_\_\_

Was your family income less than \$40,000 in the past year?  Yes  No   
 Number of family members in your household? \_\_\_\_\_

**IV. OBJECTIVE:**

List employment goals (kinds of work wanted, job title of field related to your career plan)

\_\_\_\_\_  
\_\_\_\_\_

I am willing to work within: (Circle One)            5      10      25      50      100      miles of zip code \_\_\_\_\_

**V. WORK HISTORY**

Enter the most recent employment first. If you have job experience, you must complete all required items for each employer.

Employer \_\_\_\_\_ Start Date \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ Wage \_\_\_\_\_ per hour/ week/ month/ year Hours per week \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ Country, if not US \_\_\_\_\_  
Job Title \_\_\_\_\_ Reason for Leaving \_\_\_\_\_

If you were laid off from your job, please fill in the last date of employment \_\_\_\_/\_\_\_\_/\_\_\_\_

If the plant closed, please indicate the date of closure \_\_\_\_/\_\_\_\_/\_\_\_\_

Job Duties \_\_\_\_\_

Employer \_\_\_\_\_ Start Date \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ Wage \_\_\_\_\_ per hour/ week/ month/ year Hours per week \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ Country, if not US \_\_\_\_\_  
Job Title \_\_\_\_\_ Reason for Leaving \_\_\_\_\_

If you were laid off from your job, please fill in the last date of employment \_\_\_\_/\_\_\_\_/\_\_\_\_

If the plant closed, please indicate the date of closure \_\_\_\_/\_\_\_\_/\_\_\_\_

Job Duties \_\_\_\_\_

Job Skills: List at least one. Include skills and abilities that you used in your job(s) or that you have learned through school or training. For example, laboratory techniques, carpentry, welding, ability to read blueprints, typing, computer skills such as word processing software, programming languages, or computer assisted design.

\_\_\_\_\_  
\_\_\_\_\_

I attest that the above information is true and accurate to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Downtown Rochester  
255 North Goodman St.  
Rochester, NY 14607  
T: 585-258-3500  
Monday - Thursday  
8:30 am - 4:30 pm  
Friday, 8:30 am - 12:00 pm

Department of Labor  
276 Waring Rd.  
Rochester, NY 14609  
T: 585-266-7760  
Monday - Friday  
8:30 am - 4:30 pm



## RochesterWorks! Membership Registration

Please answer the following questions and complete the attached Customer Registration Form so that you can become a member of RochesterWorks! and take advantage of our Career Center services.

1) What kind of job or career are you looking for?

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2) Are there any jobs in this field?  Yes or  No or  Not sure

3) Do you have the skills and training to find the job you want?  Yes or  No or  Not sure

4) Here are some common barriers to employment. Please check any which you think may effect your ability to find or keep a job:

- Lack of skills/education/training
- Lack of experience or an inconsistent work history
- Poor interviewing Skills
- Inadequate job search tools (resume, cover letter, etc.)
- Age
- Physical or mental disability
- Transportation limitations
- Lack of childcare
- Family problems
- Legal/criminal issues
- Other \_\_\_\_\_
- Other \_\_\_\_\_

5) Any additional comments about your job search or career goals \_\_\_\_\_

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RochesterWorks! is an equal opportunity program.  
Auxiliary aids and services are available upon request to individuals with disabilities.