

# INTAKE FORM

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

Case # \_\_\_\_\_

CIN # \_\_\_\_\_

Case Type: \_\_\_\_\_



# OPMI

Business School

116 John Street Suite 200 (2nd Floor) New York, NY 10038  
Phone: 212-269-4000 | Fax: 212-269-9070 | [info@opmi.edu](mailto:info@opmi.edu)

## IDENTIFICATION

Last Name	First Name
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SSN

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Date of Birth MM/DD/YYYY

Gender

☐ MALE

☐ FEMALE

Residence Street	Apt #	City	State	Zip Code	Phone #
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COUNSELOR	Phone #	How did you hear about us?
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## EMERGENCY CONTACTS

In case of an emergency, please contact:

Name
Phone #

E- mail Address:
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## QUESTIONNAIRE

Please tell us about yourself.

Education Status	
<input type="checkbox"/> High School Graduate	<input type="checkbox"/> Some College
<input type="checkbox"/> GED	<input type="checkbox"/> Dropout
<input type="checkbox"/> College Graduate	Last Grade Attended: _____

Annual Household Income: _____	
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered

Number of individuals living in household including yourself: \_\_\_\_\_

Do you have any children? ☐ No ☐ Yes How many? \_\_\_\_\_

How many children do you have full custody of? \_\_\_\_\_  
Please indicate N/A if not applicable.

Are you interested in training? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If YES, please check all that apply:	
TEST PREPARATION	OFFICE SKILLS
<input type="checkbox"/> GED <input type="checkbox"/> TOEFL <input type="checkbox"/> NCLEX	<input type="checkbox"/> MS Office <input type="checkbox"/> Medical Office
ENGLISH	<input type="checkbox"/> Accounting <input type="checkbox"/> Graphic Design
<input type="checkbox"/> Level _____	

Are you bi-lingual? <input type="checkbox"/> No <input type="checkbox"/> Yes, select all that apply:	
<input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Hindu	
<input type="checkbox"/> Creole/French <input type="checkbox"/> Russian <input type="checkbox"/> Other _____	

## ANSWER FOR JOB PLACEMENT PURPOSES ONLY

What hours can you work?	
<input type="checkbox"/> AM (Morning/Late Night)	<input type="checkbox"/> PM (Afternoon/Evening)
<input type="checkbox"/> Weekdays	<input type="checkbox"/> Weekends

Specify your THREE (3) main career choices:		
MAINTENANCE	HUMAN SERVICES	CLERICAL/OTHER
<input type="checkbox"/> Janitorial	<input type="checkbox"/> Child Care	<input type="checkbox"/> Customer Svc
<input type="checkbox"/> Mechanic	<input type="checkbox"/> Health Care	<input type="checkbox"/> Data-Entry
<input type="checkbox"/> Food Service	<input type="checkbox"/> School Aide	<input type="checkbox"/> Secretary
<input type="checkbox"/> Construction	<input type="checkbox"/> Hospital Work	<input type="checkbox"/> Receptionist
<input type="checkbox"/> Security	<input type="checkbox"/> Home Health Aide	<input type="checkbox"/> Sales
<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Livery/Taxi	<input type="checkbox"/> Courier/Mailroom/Messenger

Are you currently working? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have any licenses/certificates? <input type="checkbox"/> No <input type="checkbox"/> Yes Please specify. _____	
Do you have any references? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a resume? <input type="checkbox"/> No <input type="checkbox"/> Yes	

_____	MM / DD / YYYY
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PARTICIPANT'S SIGNATURE

DATE

_____	MM / DD / YYYY
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INTAKE SPECIALIST'S SIGNATURE

DATE