PERSONAL INFORMATION				DATE:		
Referred by:						
Name:						
Last	First	Middle	SSN			
Address:						
Street	C	lity	State	Zip Code		
Home #:	Wor	·k #:		Cell #:		
Position:		D	ate Available:			
Are you seeking: 🗆 1	Full-time 🗆 Part-time	e □ Relief staf	f 🗆 Anv Ava	ilable		
			-			
What days and hours	s are you available to	work?			-	
		-		city you wish to work:		
	each 🗆 Norfolk 🗆 (TRAINING : Please	-		☐ Any r training background that i	s	
relevant to the job yo		indicate your c		i tunning buokground that i	.0	
	Name & Location		Did You	Subject		
High School	of School	Attended	Graduate?	Studied		
College						
Certifications and Tr	ainings			·	_	
					-	
Are you a licensed [)river? Yes No	Driver's Lic	ense #·	State:		
					?	
	es, Explain			nor motor vehicle violation	-	
					_	
					-	
Do you have a histor paper.	y of substance abuse	? Yes No _	If yes, Exp	lain on a separate sheet of		

Charis Support Services Application for Employment

Date/Month/ Year	Name and Phone # of Former/Current Employee	Salary	Position	Reason for leaving
	~			
<u>EFERENCES:</u> Name	Give names of three persons Business & Address		<u>sional and one per</u> hone Number	sonal Years Acquainted
				1
	will require tasks such as liftir			
	e required to use physical inter			
vhavior. Do you yes, please exp	u have any limitations that ma	iy affect your	ability to perform	these tasks? \Box Yes \Box
yes, please exj	Jam			
•	will require that we are able to	•		emergency or shift change.
•	urrent, active telephone numb			
	Charis Support Services for D tand that the needs of the clier			erefore I may be assigned a
different	shift or location to meet those	e needs.		
	ovide the information and rele bmit verification of automobil			
• I will su employr				te filst filteen days of fily
• I will ob	tain and submit the results of	a tuberculos	s (TB) test within	the first fifteen days of
• Lunders	nent. tand that I will be required to I	have a vehic	le available to use	on a regular basis during all
shifts we	orked.			
	tand that during the course of -excluded provider.	my employn	nent I must meet a	ll of the standards of HHS-O
	agree that, if hired, my emplo			
e date of paym	ent of my wages and/or salary	y be terminat	ed at any time wit	hout prior notice and without
ne date of paym ause. I certify tl		y be terminat application a	ed at any time with re true and comple	hout prior notice and without ete to the best of my knowled

I authorize investigation of all statements contained herein and the references listed above give you any all information concerning my previous employment and any pertinent information they may have, and release all parties from liability for any damage that may result from furnishing the same to you.

SIGNATURE

ADMINISTRATION USE ONI	
	Date:
INTERVIEWED BY:	TITLE:
REMARKS:	
NEATNESS:	
HIRED: YES NO	
IF YES, WHAT POSITION:	PROGRAM:
SALARY/WAGE:	DATE REPORTING TO WORK:
APPROVED BY ADMINISTRAT	OR: YES NO DATE:
OTHER COMMENTS:	