APPLICATION FOR EMPLOYMENT

(All positions are “At-Will” Employees)

Chosen Vision, Inc. is an equal opportunity employer and will not discriminate against any applicant in accordance with state and federal laws. Please note that this application will only remain active for six months from the date of completion, after which the applicant will need to re-apply.

Position Applied for:  Date:

Date you would be available to begin employment if offered a position:

First Name:  Last Name:

Social Security # Date of Birth:

Present Address**:**

City: State: Zip

Telephone: Home  Work  Cell

E-Mail address:

Type of employment desired:

Are there any hours or days of the week you cannot work?

If **YES**, what are they?

Are you employed now? . May we contact your present employer?

If NO, please explain

Employer: Supervisor:  Phone: Email:

Emergency Contact:

Name:

Relation

Phone

Have you ever been convicted of a misdemeanor or felony violation? .

If your answer is **YES**, please explain the

* nature of the violation
* when it occurred
* circumstances

State law requires that you submit a set of fingerprints to the Michigan Department of State Police. Furthermore, state law requires that you report to the administrator of Chosen Vision any time you are arraigned for a criminal offense (see Policy Item 440). Do you agree to comply with these requirements? .

The position you applied for requires driving. Do you currently have a valid driver’s license? .

Driver’s license #

Have you received a citation for speeding or other traffic violations within the past five years? .

If your answer is **YES**, please explain the

* nature of the offense
* when it occurred
* circumstances

Have you ever been determined by a federal, state or local governmental agency to have committed abuse or neglect? .

If your answer is **YES**, please explain the

* nature of the offense
* when it occurred
* circumstances

# **EDUCATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Dates AttendedTO / FROM | Name of School | City, State | Area of Study | Degree Rec’d |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

# **EMPLOYMENT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| TO / FROM | Employer | Address & Phone | Contact Person | Rate of Pay |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

May we contact your employers? .

Please identify which employer you do not wish us to contact and the reason for your request.

**REFERENCES** – please list three references of people to whom you are not related and who will have personal knowledge regarding your ability to care for developmentally disabled adults.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Address | Phone | Email | Affiliation |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Please read the following statement carefully before signing to indicate your understanding.

I understand that prior to being offered employment, I may be requested to take an employment examination.

I certify that the facts contained in this application are true, accurate, and complete to the best of my knowledge and understand that, if employed, falsified statements, or omitted material facts on this application may result in my disqualification from consideration for employment, or termination from employment if I have been hired.

I understand and agree that, if hired my employment is as an “At-Will Status” employee. I have been provided an opportunity to read Policy Item # 401 and understand the meaning of that term and will accept employment with Chosen Vision, Inc. in accordance with that policy item. This provision supersedes any oral or written representation to the contrary.

I authorize Chosen Vision, Inc. to investigate my background and to determine the accuracy of all statements contained in this application for any employment-related purpose. I release the listed references and all employers, except those specifically exempted as requested in writing. I hereby release these references and former employers from all liability for any information they may give to chosen Vision, Inc.

I hereby consent to the release of this application to representatives of those state agencies and Community Mental Health agencies who have statutory responsibility for the regulation of Chosen Vision and the residents of Chosen Vision. I hereby release Chosen Vision Inc. and all such persons from liability or damages incurred because of this inquiry and disclosing this information. I understand that any claim or lawsuit relating to my service with Chosen Vision, Inc. must be filed no more than six months after the date of the employment action that is the subject of the claim or lawsuit. I waive any statute of limitations to the contrary.

Applicant’s Signature  Date

Note: Application may be e-mailed to chosenvision@comcast.net

Applicant’s signature will be required at the time of interview.