The Cerebral Palsy Center
Cerebral Palsy Housing Corporation

Phone (865) 523-0491
Fax (865) 523-0492

Application for Employment

Please **PRINT** all information clearly:

Date of Application: _____ Date Available for Work: _____

Are you available to work: ❑Full Time ❑Part Time ❑Temporary ❑PRN (as needed)

Position(s) Applied for: _____

Name: _____
First Middle Last

Address: _____
Street/PO Box City State Zip

Home Telephone # ( ) _____-_____ Social Security #_____-_____-_____
Alternate Telephone # ( ) _____-_____

Are you at least 18 years old? ..... ❑Yes ❑No

If hired, can you present evidence of U.S. Citizenship or your legal right to live and work in this country? ..... ❑Yes ❑No

Have you even been convicted of a felony, excluding misdemeanors and summary offenses? ..... ❑Yes ❑No

Were you previously employed by us? ..... ❑Yes ❑No
If yes, when? _____

Have you ever been bonded? ..... ❑Yes ❑No
If yes, on what jobs? _____

Have you ever been in the U.S. Armed Forces? ..... ❑Yes ❑No
If yes, what Branch? _____ Dates of Duty: From _____ To _____

Rank at Discharge: _____

Describe your duties in the service, as well as any special training you received:

_____

_____

_____

Employment History

Starting with your **most recent** job, please provide the following information. If you run out of space, you may continue on the back of this page. **We must have a telephone number for all past jobs.**

1	Employer	Dates Employed		Work Performed
	Address	From	To	
	Telephone #	Hourly Rate/Salary		
	Supervisor's Name	Start	End	
	Reason for Leaving			
2	Employer	Dates Employed		Work Performed
	Address	From	To	
	Telephone #	Hourly Rate/Salary		
	Supervisor's Name	Start	End	
	Reason for Leaving			
3	Employer	Dates Employed		Work Performed
	Address	From	To	
	Telephone #	Hourly Rate/Salary		
	Supervisor's Name	Start	End	
	Reason for Leaving			
4	Employer	Dates Employed		Work Performed
	Address	From	To	
	Telephone #	Hourly Rate/Salary		
	Supervisor's Name	Start	End	
	Reason for Leaving			
5	Employer	Dates Employed		Work Performed
	Address	From	To	
	Telephone #	Hourly Rate/Salary		
	Supervisor's Name	Start	End	
	Reason for Leaving			

May we contact the employers listed above? ..... ❑Yes ❑No
If no, indicate by number the ones that you DO NOT want us to contact _____.

Do you know anyone who works at the Cerebral Palsy Center or CPHC? ❑Yes ❑No
If yes, please list name (s):_____

Education

	School Name and Address	Course of Study	Did you Graduate?	Diploma or Degree
Elementary			Y N	
High			Y N	
College			Y N	
Other (describe)			Y N	

Skills and Qualifications

List any experience, skills, qualification, or other training you have that you feel would especially qualify you to work with the Cerebral Palsy Center or CPHC:

_____

_____

_____

_____

_____

Personal References

Please list three persons, including one who has known you **for at least 5 years**. Please do not list relatives.

Name	Phone Number	Years Known

May we contact the personal references listed above?..... ❑Yes ❑No

The facts set forth above in my Application for Employment are true and complete. I understand that, if I am employed by the Cerebral Palsy Center or CPHC, false statements on this application shall be considered sufficient cause for dismissal.

Signature:_____ Date: _____

REQUIREMENTS FOR EMPLOYMENT

Applicants for employment by the Cerebral Palsy Center and the Cerebral Palsy Housing Corporation (CPHC) should be aware of the following information:

NON-DISCRIMINATION POLICY

We consider applicants without regard to race, color, religion, gender, age, national origin, disability, marital or veteran status, sexual orientation, or any legally protected status.

EDUCATION

All employees must have a high school diploma or GED. Some positions require more education, skills, or training. In order to be considered for employment, you must provide proof of your education for our records.

LICENSE

All employees who transport consumers as part of their job duties will be asked to acquire a Class D, F endorsement, Tennessee Drivers License within 30 days of employment. All employees must have a clean driving record in order to drive center vehicles or transport consumers. An MVR will be requested from the Department of Motor Vehicles.

SCREENING

Tuberculosis (TB): All employees must be screened for TB within the first 30 days of employment. A licensed physician or the Health Department must perform this screening. You must present, for our records, a written certificate stating that you are free of TB.

Criminal History: Employees who will have contact with or responsibility for persons with developmental disabilities must undergo a criminal history background check. You will be required to complete a release form before this check can be conducted. Applicants with a felony record are not eligible for employment.

Drug Screening: All employees must submit to urinalysis and/or other tests for the purpose of determining the drug content thereof upon employment offer An employee with a confirmed positive test result will be denied employment

TRAINING

You must complete pre-service training before working with consumers. Additional core training must be successfully completed within 60 days of employment. The Cerebral Palsy Center or CPHC will pay for this training. Employees must complete all training with a grade of 80% or higher.

AFFIRMATION

I, the undersigned applicant, certify and affirm that, to the best of my knowledge and belief; I have or have not (circle as applicable) had a case of abuse, neglect, mistreatment, or exploitation substantiated against me. As a condition of submitting this application in order to verify this affirmation I further release and authorize The Cerebral Palsy Center and the Tennessee Department of Mental Retardation Service to have full and complete access to any and all current or prior personnel or investigative records from any party, person, business or agency, as pertains to any allegations against me of abuse, neglect, mistreatment, or exploitation and to consider this information as may deemed appropriate.

I understand that failure to complete the requirements for license, screening, and training within the required schedule may result in disciplinary action or dismissal.

_____ _____

Signature Date

Equal Employment Opportunity and Tennessee Drug-Free Workplace

Copy of Release of Information

SECURITY WALLS llc
Impenetrable Protection & Investigative Services

I, _____ ***(print)***, authorize Security Walls, LLC to make whatever inquiries it deems necessary in connection with my application for employment or in the course of review of any employment. I authorize all persons, schools, companies, corporations, credit bureaus, department of motor vehicles and law enforcement agencies to supply information concerning my background. I release Security Walls, LLC, Trans Union, and all persons who provide information to Security Walls, LLC concerning me, from all liability or any damages on account of inquiry into and the furnishing of said information.

A photocopy of this authorization shall be deemed an original and shall be accepted as such by every person. I understand that I have the right to request a copy of any report by writing to Security Walls, LLC within 60 days. The fee for this report will be paid at my expense to Security Walls, LLC. As per the Fair Credit Reporting Act, I am entitled to know if employment is denied because of information obtained from a consumer reporting agency such as Security Walls, LLC.

_____ _____
Signature Date Date of Birth

_____ _____
Other names used Social Security Number

_____ _____
Name as it appears on driver's license D.L. Number State

_____
Address City/State Zip

(_____)_____
Phone Number (Must Be Provided Before Processing)

Requested By: _____**Cerebral Palsy Center** _____

Please print or type all information

All forms must be faxed to 865-546-2932 to respect individuals' privacy.

Fair Credit Reporting Act (FCRA) Disclosure Regarding Consumer Reports

Cerebral Palsy Center, as a condition of your employment (post-offer/pre employment), when deciding whether to continue your employment (if you are hired), and when making other employment related decisions directly affecting you, may wish to obtain and use a "consumer report" from a "consumer reporting agency." These terms are defined in the Fair Credit Reporting Act ("FCRA"). As an applicant for employment or employee of **Cerebral Palsy Center**, you are a "consumer" with rights under the FCRA.

A "consumer reporting agency" is a person or business which, for monetary fees, dues or on a cooperative nonprofit basis, regularly assembles or evaluates consumer credit information or other information on consumers for the purpose of furnishing "consumer reports" to others, such as **Cerebral Palsy Center**

A "consumer report" is any written, oral or other communication of any information by a "consumer reporting agency" bearing on a consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living which is used or collected for the purpose of serving as a factor in establishing the consumer's eligibility or continued eligibility for employment purposes.

If **Cerebral Palsy Center** obtains a "consumer report" about you, and if **Cerebral Palsy Center** considers any information in such report when making an employment related decision that directly and adversely affects you, you will be provided with a copy of the "consumer report" before the decision is finalized. You also may contact the Federal Trade Commission about your rights under the FCRA as a "consumer" with regard to "consumer reports" and "consumer reporting agencies."

Please be advised that you have the right to request, in writing, within a reasonable time, that we make a complete and accurate disclosure of the nature and scope of the information requested. Such disclosure will be made to you within 5 days of the date on which we receive the request from you or within 5 days of the time the report was first requested, whichever is later.

Applicant's Name (Please Print)	Social Security Number
Applicant's Signature	Date

Building Lives, Building Futures

CEREBRAL PALSY CENTER

STATEMENT AUTHORIZING RELEASE OF INFORMATION

Date: _____

Name of Agency & Region: Cerebral Palsy Center for Handicapped Adults, Inc. –East Region

Full Name of Applicant/Employee: _____

Previously used names (nicknames, maiden name, etc.): _____

SS#: _____

Date of Birth: _____

Date of Hire: _____

DL#: _____

State of DL: _____

I, _____, certify and affirm that, to the best of my knowledge and belief, I ___ have / ___ have not had a case of abuse, neglect, mistreatment or exploitation substantiated against me. In order to verify this affirmation, I release and authorize the Cerebral Palsy Center and the Tennessee Department of Intellectual and Developmental Disabilities (DIDD) to have full and complete access to any and all current or prior personnel or investigative records, from any party, person, business, entity or agency, whether governmental or non-governmental, as pertains to any allegations against me of abuse, neglect, mistreatment or exploitation and to consider this information as may be deemed appropriate. This authorization extends to providing any applicable information in personnel or investigative reports concerning my employment with this employer to my future employers who may be providers of services under contract with DIDD.

Signature of Applicant/Employee: _____

Date: _____

Witness: _____

Date: _____

MW

Revised 7/30/15