

Application for Employment

(Fully complete both pages)

_____ Date of Application

Please Print

Social Security Number	Last Name	First Name	Middle Name
Address (street number and name)		City	County
State	Zip Code	Phone (home or where you can be reached)	Business Phone

Position Applied For: _____

Date of Birth: / / N. C. Driver's License Number _____
(month) (day) (year)

Have you ever been convicted of breaking a law other than a minor traffic violation?

YES NO If yes, give the date and explain fully on an additional piece of paper if more space is needed

Have you ever had a Department of Social Services (DSS) substantiation?

YES NO If yes, list county/State and give the date and explain fully on an additional piece of paper if more space is needed

(The offense(s) and how recently you were convicted will be evaluated in relation to the job for which you are applying.)

Education

Circle the highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 GED College 1 2 3 4

Schools	Name and Location	Dates Attended	Course of Study	Degree/Diploma
High School				
		to		
College or University		to		
		to		
		to		
		to		
		to		
Graduate or Professional		to		
		to		
Educational, Vocational Schools, etc.		to		
		to		
		to		
		to		

Child care training you have completed in the last three years (such as first aid, CPR, CDA, ITS-SIDS, etc.):

References

List the names, addresses and phone numbers of two people we may contact as references:

Work History

(List child care/early childhood experience first.)

Current or Last Employer			Address		
Job Title			Supervisor's Name		No. Supervised by you
Date Employed (mo/yr)	Starting Salary \$ Per	Ending Salary \$ Per	Reason for leaving		May we contact employer? yes no
Date Separated (mo/yr)			Duties:		
Full Time	Years	Months			
Part Time	Years	Months			
If part time, number of hours per week					

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Date Separated (mo/yr)			Duties:		
Full Time	Years	Months			
Part Time	Years	Months			
If part time, number of hours per week					

I certify that I have given true, accurate, and complete information on this form to the best of my knowledge. In the event confirmation is needed in connection with my work, I authorize educational institutions, associations, registration, and licensing boards, and others to furnish whatever detail is available concerning my qualifications. I authorize investigations of all statements made in this application and understand that false information of documentation, or a failure to disclose relevant information may be grounds for rejection of my application, disciplinary action, or dismissal if I am employed, and (or) criminal action. I further understand that dismissal on unemployment shall be mandatory if fraudulent disclosures are given to meet position qualifications.

Signature of Applicant _____ Date _____

EMERGENCY INFORMATION ON STAFF

NAME: _____	
ADDRESS: _____	
NAME OF DOCTOR: _____	PHONE: _____
HOSPITAL PREFERENCE: _____	PHONE: _____
NAME OF DENTIST: _____	PHONE: _____
To avoid any adverse drug reaction during an emergency, please list medications you are taking: _____	

ALLERGIES: _____	
BLOOD TYPE (If known.) _____	
LIST OPERATIONS OR HOSPITALIZATIONS WITHIN THE PAST YEAR: _____	

LIST CHRONIC MEDICAL PROBLEMS REQUIRING A DOCTOR'S CARE: _____	

EMERGENCY CONTACT PERSONS:	
NAME: _____	RELATIONSHIP _____
ADDRESS: _____	
HOME PHONE: _____	BUSINESS PHONE: _____
NAME: _____	RELATIONSHIP _____
ADDRESS: _____	
HOME PHONE: _____	BUSINESS PHONE: _____

STAFF HEALTH QUESTIONNAIRE

IMPORTANT — Current health information must be completed annually by:
All staff (including the director). (2) All volunteers* and substitutes* prior to their coming into contact with the children.

NAME: _____	
HOME ADDRESS: _____	
TELEPHONE NUMBER: _____	
HEALTH STATUS:	
1. I am in excellent mental and physical health and am free of communicable disease. (If no, please explain.) _____	

2. I take the following medications regularly (please explain): _____	

This health statement is accurate to the best of my knowledge. I will advise the director if my health status changes.	
Signature: _____	Date: _____

*Any substitute or volunteer who is counted in the mandatory staff-child ratio must comply with the health standards for staff.	

Staff Medical Report

(To be completed by all staff and placed on file within 60 days of initial employment)

NAME _____
Last First Middle

HOME ADDRESS _____

TELEPHONE NUMBER _____

TO BE COMPLETED BY THE PHYSICIAN:

Some lifting of young children and some picking up and moving of furniture and equipment may be required. Since we are vitally involved with the wholesome emotional growth of the child, we require good mental and physical health of our employees.

Does this applicant have any physical condition which would limit their work with children? If yes, please describe: _____

Is this applicant currently under treatment which would preclude their work with children? If yes, please describe: _____

Is this applicant currently under treatment for any specific condition? If yes, please describe: _____

Is this applicant currently taking any medication that would affect his/her work with children? If yes, please describe: _____

In your opinion, is this applicant emotionally and physically capable to care for children on a daily basis?

Date of Examination

Signature of Physician

Phone Number

Address

Tuberculin (TB) Test

All staff members are required to have a negative test result before coming in to contact with children. Volunteers and Substitutes present more than once per week must also have evidence of a negative test.

NAME _____
Last First Middle

HOME ADDRESS _____

TELEPHONE NUMBER _____

Evidence of tuberculin test:

Type of test _____ Date given _____

Results Negative Positive

Comments:

Signature of Authorized Health Professional

Address

Phone Number

STAFF FILE CHECKLIST

Name of Employee: _____ Date of Employment: _____

The following items must be present in each staff member's personnel file, except for items marked (*) which are only required for centers meeting voluntary enhanced standards.

Item	Date Received/Completed
<input type="checkbox"/> Employment Application	
<input type="checkbox"/> Initial Medical Report	
<input type="checkbox"/> TB Test Results	
<input type="checkbox"/> Annual Health Questionnaire	
<input type="checkbox"/> Emergency Information	
<input type="checkbox"/> Documentation of Orientation	
<input type="checkbox"/> Documentation of In-service Training	
<input type="checkbox"/> Documentation of CPR/FA	
<input type="checkbox"/> Documentation of Playground Safety	
<input type="checkbox"/> Documentation of BSAC	
<input type="checkbox"/> Criminal Records Check Letter or copies of submitted documents	
<input type="checkbox"/> Credential Verification or Education Equivalency Info	
<input type="checkbox"/> Annual Staff Development Plan*	
<input type="checkbox"/> Annual Staff Evaluations*	
<input type="checkbox"/> Documentation of Job Descriptions Receipt*	
<input type="checkbox"/> Documentation of Operational and Personnel Policy Receipt*	