



ADVANCING OPPORTUNITIES/CEREBRAL PALSY OF NEW JERSEY, INC.
1005 Whitehead Road Extension, Suite 1
Ewing, New Jersey 08638

EMPLOYMENT APPLICATION

PERSONAL INFORMATION:

Date: _____

Name: _____
Last First Middle

Present Address: _____
Street City State Zip

Permanent Address
(If Different): _____
Street City State Zip

Phone: Home: () _____ Other : () _____

Email: _____ Referred by: _____

Are you a citizen of the U.S.? Yes [] No []

If no, are you a legal resident or have a valid work permit? Yes [] No []

Do you have a valid driver's license? (If applicable to position) Yes [] No []

Are you at least 18 years of age? Yes [] No []

EMPLOYMENT DESIRED:

Position: _____ Date available: _____ Desired salary: _____

Are you employed? Yes [] No [] If yes, may we contact your employer? Yes [] No []

Are you willing to travel? Yes [] No [] If yes, in which counties? _____

Days/Hours available

Sun	Mon	Tue	Wed	Thur	Fri	Sat

Have you ever worked for this agency before? Yes [] No [] If yes, when? _____

Which office? _____ Reason for leaving: _____

PHYSICAL RECORD:

Is there any reason known to you why you might be unable to perform consistently and promptly any of the job duties after reasonable accommodations are made? Yes [] No []

If yes, please explain: _____

EDUCATION HISTORY:

(If this information is contained on resume, please indicate below and attach)

Education	Name and Location	Years Attended	Degree Received
High School			
College			
Trade, Business or Correspondence School			
Graduate Licensed Training			

EMPLOYMENT INFORMATION:

(If this information is contained on resume, please indicate below and attach)

Please list your previous three employers, beginning with the most recent

Date month / year	Employer name, address and phone	Supervisor	Salary	Position	Reason for leaving
From: To:					
From To:					
From: To:					

ADDITIONAL INFORMATION:

Training's and Certification: (Please check all that apply)

- | | |
|------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Adult CPR | <input type="checkbox"/> Medication Administration |
| <input type="checkbox"/> Infant/Child CPR | <input type="checkbox"/> Nurses /Home Health Aide |
| <input type="checkbox"/> Blood borne Pathogens | <input type="checkbox"/> Personal Attendant/Homemaker |
| <input type="checkbox"/> Crisis Intervention | <input type="checkbox"/> Preventing Abuse & Neglect |
| <input type="checkbox"/> DD Overview | <input type="checkbox"/> Standard First Aid |
| <input type="checkbox"/> Employment Specialist | <input type="checkbox"/> Other _____ |

Special activities, experiences, or certifications/licenses that may be job-related: _____

Which languages do you speak fluently? _____

Read: _____ Write: _____

Military Services? _____ Rank _____ Present Membership in National Guard/Reserves _____

Are you now abusing any addictive substance? Yes [] No []

Have you ever been adjudged civilly or criminally liable for the abuse of any person with disability?

Yes [] No []

Have you ever been convicted of a crime? Yes [] No []

If yes, for each conviction, provide the nature of the offense, the date of the conviction, the court and the sentenced imposed. (Conviction of a crime does not necessarily disqualify you from employment).

Any offer of employment at Advancing Opportunities/Cerebral Palsy of New Jersey, Inc is conditional upon satisfactory completion of a drug test. Applicants who refuse to submit to drug testing will be disqualified from consideration for employment with Advancing Opportunities/Cerebral Palsy of New Jersey, Inc.

Advancing Opportunities/Cerebral Palsy of New Jersey, Inc reserves the right to obtain a motor vehicle driver record abstract on those employment applicants who will drive for agency business.

As a condition of employment with Advancing Opportunities/Cerebral Palsy of New Jersey, Inc., all applicants who have been offered employment will be screened for criminal background history.

I AUTHORIZE INVESTIGATION OF ALL INFORMATION CONTAINED IN THIS APPLICATION. I UNDERSTAND THAT MISREPRESENTATION OR OMISSION OF FACTS PROVIDED IS CAUSE FOR IMMEDIATE DISMISSAL.

I HEREBY RELEASE THE EMPLOYER AND ANY REPRESENTATIVE ACTING ON BEHALF OF THE AGENCY FROM ANY AND ALL LIABILITY AS A RESULT OF THE REQUESTED INFORMATION FROM ANY PERSON(S). EMPLOYMENT WITH ADVANCING OPPORTUNITIES/CEREBRAL PALSY OF NEW JERSEY IS FOR NO DEFINITE PERIOD.

I UNDERSTAND THAT ADVANCING OPPORTUNITIES/CEREBRAL PALSY OF NEW JERSEY HAS AN AT WILL POLICY AND EMPLOYMENT CAN BE TERMINATED AT ANY TIME WITHOUT CAUSE OR NOTICE.

THIS FORM HAS BEEN DESIGNED TO COMPLY WITH STATE AND FEDERAL FAIR EMPLOYMENT PRACTICE LAWS PROHIBITING DISCRIMINATION ON THE BASIS OF AN APPLICANT’S SEX, MINORITY STATUS OR DISABILITY. QUESTIONS DIRECTLY OR INDIRECTLY REFLECTING SUCH STATUS HAVE BEEN INCLUDED ONLY WHEN NEEDED TO DETERMINE OCCUPATIONAL QUALIFICATION.

THE UNLAWFUL MANUFACTURING, SALE OF, DISTRIBUTION, DISPENSING, POSSESSION, OR USE OF A CONTROLLED SUBSTANCE IS PROHIBITED AT ALL ADVANCING OPPORTUNITIES/CEREBRAL PALSY OF NEW JERSEY, INC. LOCATIONS. VIOLATION OF THIS POLICY WILL RESULT IN IMMEDIATE TERMINATION.

Advancing Opportunities/Cerebral Palsy of New Jersey, Inc. is an Equal Opportunity Employer

Signature: _____ Date: _____

Revised: 3/29/06, 2/09

Personal Reference Verification

TO: Name: _____
Address: _____
Phone: (Home) _____ (Other) _____

_____ has given your name as a personal reference. We would ask you to complete the following form.
Please return this form to us by _____.

How long have you known the applicant? _____

Relationship to the applicant? _____

Please comment on the applicant's:

Character: _____

Integrity: _____

Reliability: _____

Other comments: _____

Signed: _____ Date: _____

Please return this form to: _____

Release of Information Authorization

I authorize the individual named to complete this form with requested information to Advancing Opportunities/Cerebral Palsy of New Jersey, Inc.

Applicant's Signature: _____ Date: _____

Academic Credential Verification

_____ has applied for a position and had indicated that he/she attended your educational institution. To consider anyone for employment with Cerebral Palsy of New Jersey, Inc, verification of academic achievements is required. In order to continue the employment process for this applicant, the information on this form must be returned to us by _____ .

Thank you for your assistance.

Please verify that the following information is accurate:

Name of applicant:	_____	_____	_____
	Last	First	Prior name
Name of educational institution:	_____		
Address of educational institution:	_____		

Dates attended:	_____		

Degree(s) received:	_____		

Name/Educational Institution Title Signature: _____

Please return this form to: _____

Release of Information Authorization

I authorize the educational institution named above to release the requested information and return this form to Advancing Opportunities/Cerebral Palsy of New Jersey, Inc.

Applicant's Signature: _____ Date: _____

Employment Verification

TO: Employer Name; _____

To the Attention of: _____

Address: _____

Phone: _____ (Other) _____

_____ has applied for a position with our agency and indicated that he/she worked for you. We would ask you to complete the following form.

Please return this form to us by _____.

Dates of Employment: _____

Position(s) Held: _____

Salary Level: _____

Reason for Separation: _____

Other comments about the applicant: _____

Signed: _____ Date: _____

Please return this form to: _____

Thank you.

Release of Information Authorization

I authorize the individual named to complete this form with requested information and return this form to Advancing Opportunities/Cerebral Palsy of New Jersey, Inc.

Applicant's Signature: _____ Date: _____

Employment Verification

TO: Employer Name; _____

To the Attention of: _____

Address: _____

Phone: _____ (Other) _____

_____ has applied for a position with our agency and indicated that he/she worked for you. We would ask you to complete the following form.

Please return this form to us by _____.

Dates of Employment: _____

Position(s) Held: _____

Salary Level: _____

Reason for Separation: _____

Other comments about the applicant: _____

Signed: _____ Date: _____

Please return this form to: _____

Thank you.

Release of Information Authorization

I authorize the individual named to complete this form with requested information and return this form to Advancing Opportunities/Cerebral Palsy of New Jersey, Inc.

Applicant's Signature: _____ Date: _____

CONSENT FOR PRE-EMPLOYMENT DRUG TESTING

I hereby voluntarily give my permission to be tested for drugs and/or alcohol in accordance with the Advancing Opportunities/Cerebral Palsy of New Jersey Drug and Alcohol Policy. I understand that certain drugs have lingering effects and may cause a positive testing result even if they have not been recently used. I further understand that the drug testing will include testing for adulterants.

I also give my permission for disclosure of the tests results to Cerebral Palsy of New Jersey personnel with a need to know basis. I understand that such test results will be used in making decisions which affect my employment.

I have been given a copy of the Cerebral Palsy of New Jersey Drug and Alcohol Policy. I have read it and understand it.

Employee Signature

Witness Signature

Name (Typed or Printed)

Witness (Typed or Printed)

Date

Date