



EMPLOYEE APPLICATION
INFORMATION SHEET

NAME _____ **BIRTHDATE** _____
 Last **First** **Middle**

HOME ADDRESS _____

_____ **PHONE** _____
City **State** **Zip**

EDUCATION: **E-Mail Address:** _____

Years completed: In school _____ **College** _____ **Degree** _____

School/College (s) Attended _____

EMPLOYMENT:

Current: _____ **Business Phone** _____

Previous: _____

Have you ever worked with persons with disabilities? _____

Examples of experience: _____

Do you speak another language? _____ **If so, what** _____



WORK AVAILABILITY:

Program hours vary from 7:30 a.m. to 5:30 p.m. Monday through Friday. Check which days and write times you are available.

Monday	_____	from	_____	to	_____
Tuesday	_____	from	_____	to	_____
Wednesday	_____	from	_____	to	_____
Thursday	_____	from	_____	to	_____
Friday	_____	from	_____	to	_____

How did you hear about The Arc? _____

REFERENCES:

List three local references. If one is a previous employer, put an "E" before the name.

	NAME	ADDRESS	PHONE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Signature

Date



TREATMENT/NON-CONVICTION and
CONFIDENTIALITY STATEMENT

The following information must be completed and submitted before starting work as a caregiver in any of The Arc of McLennan County's Programs.

1. TREATMENT STATEMENT:

I, (print full name) _____, state that:

I am not currently receiving treatment for alcoholism, drug abuse and/or child abuse problems.

I have never received treatment for alcoholism, drug abuse and/or child abuse problems.

I am currently receiving treatment for: (check the treatment)

alcoholism **drug abuse** **child abuse**

DATE _____ SIGNATURE _____

2. NON-CONVICTION STATEMENT:

I, (print full name) _____, declare that I have never been convicted of a felony or misdemeanor in any State, including sex-related or child-abuse related offenses.

DATE _____ SIGNATURE _____

3. CONFIDENTIALITY STATEMENT:

I, (print full name) _____, am aware that conversations, records and events pertaining to The Arc's Program enrollees (children) and their parents are confidential and I agree to refrain from discussing same outside of the Program and NO Cell Phone pictures.

DATE _____ SIGNATURE _____



Employee File Information
IN CASE OF AN EMERGENCY:

Your Name: _____

Who to Contact:

Name: _____

Address: _____

Telephone Number:

Home: _____

Cell: _____

Work: _____

CHILD CARE LICENSING REQUEST FOR BACKGROUND CHECK

"Texas law gives you the right to know what information is collected about you by means of a form you submit to a state government agency. You can receive and review this information, and request that incorrect information about you be corrected by contacting your licensing representative."

Operation Name The Arc Summer Day Camp		Operation Number 1319369	Telephone No. (A/C) (254) 405-4500 - Cell *(254) 756-7491
Operation Address (Street, City, ZIP) 1300 Austin Avenue		Operation Mailing Address (City & Zip) Waco, TX 76701	County McLennan

Complete the following information for each person required to have a background check. All names used currently or in the past must be provided. If you do not provide every name that each person has used, you may receive inaccurate results. Additional forms may be obtained from the Licensing office.

I verified (by reviewing the person's social security card and/or driver license) that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge. I understand that the Department may contact others and, at any time, seek proof of any information contained here. I understand that any willful misrepresentation or failure to provide identifying information within the stated time limit is a cause for denial of the application or revocation of my license, registration or listing.

Thomas C. Pearson
Printed Name of Director, Owner, or Operator Signature of Director, Owner, or Operator Date

<input type="checkbox"/> Initial		<input type="checkbox"/> 24 Month Check		<input type="checkbox"/> Fingerprint Check Required		<input type="checkbox"/> FBI Results in DPS Clearinghouse	
Social Security Number				ID Type - Drivers License or ID Number -State			
First Name		Middle Name		Last Name			
Street Address		City		State		Zip	
County		Telephone No. (A/C)		Date of Birth		Gender <input type="checkbox"/> M <input type="checkbox"/> F	
You must list any other city in Texas where this person has been a resident, and any addresses, including county, where the person has lived outside of Texas in the previous five years:							
Relationship of person to requestor							
<input type="checkbox"/> Adoptive Parent		<input type="checkbox"/> Caregiver		<input type="checkbox"/> Director		<input type="checkbox"/> Foster parent	
<input type="checkbox"/> Other Staff		<input type="checkbox"/> Staff		<input type="checkbox"/> Volunteer		<input type="checkbox"/> Household Member	
				<input type="checkbox"/> Licensed Administrator		<input type="checkbox"/> Other:	
For Foster/Adoptive Homes only: Relationship between child/children to be placed and the foster/adoptive parent(s) or prospective foster/adoptive parent(s)							
<input type="checkbox"/> Relative		<input type="checkbox"/> Fictive Kin		<input type="checkbox"/> Unrelated			
Date Hired /Used by the Operation/Agency		Ethnicity (must accompany race) <input type="checkbox"/> Hispanic <input type="checkbox"/> Other		Race			
				<input type="checkbox"/> White		<input type="checkbox"/> Asian	
				<input type="checkbox"/> Black		<input type="checkbox"/> American Indian/Alaskan Native	
				<input type="checkbox"/> Unable to Determine		<input type="checkbox"/> Native Hawaiian/ Pacific Islander	
Other names used (married, maiden, etc.) First Name		Middle Name		Last Name			

DFPS Use Only	Worker Name--Last, first	Mail Code
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