



**EMPLOYEE APPLICATION**  
**INFORMATION SHEET**

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
          Last           First           Middle

HOME ADDRESS \_\_\_\_\_  
\_\_\_\_\_  
          City           State           Zip           PHONE \_\_\_\_\_

**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 \_\_\_\_\_



APPLICANT'S NAME: \_\_\_\_\_

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	_____

ABILITIES:

Do you have a current: TB Skin Test \_\_\_\_\_  
Red Cross First Aid Certificate \_\_\_\_\_  
CPR Certificate \_\_\_\_\_

List any interests or talents. (Art, Crafts, Singing or Playing an Instrument, Story Reading, Indoor & Outdoor Games, etc.)

\_\_\_\_\_  
\_\_\_\_\_

How did you hear about The Arc and our Program? \_\_\_\_\_

\_\_\_\_\_

Any prior experience working with children and/or challenged children?

\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



List Professional Training, Certificates and Licenses (including CEUs):

First Aid Training: \_\_\_\_\_ Date Completed: \_\_\_\_\_

CPR Training: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Blood Borne Pathogens: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Sexual Harassment: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Whistle Blower: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Medicine Distribution Safety: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Confidential Information: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Child Abuse and Neglect: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Safety and Transportation: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Other: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Physical Record and Qualifications:

Are there any physical or personal limitations on the type of work you would be required to do in performing your duties and the hours to be worked?

\_\_\_\_\_

Can you walk a moderate distance? \_\_\_\_\_

Can you lift up to 50 lbs. by yourself? \_\_\_\_\_

**Please submit a copy of your Driver's License with this application  
for the background check.**



**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 <b>The Arc of McLennan County School Age Program</b>		Operation Number <b>1709365</b>	Telephone No. (A/C) <b>254-756-7491/405-5500</b>
Operation Address (Street, City, ZIP) <b>4901 Lakewood Drive - Waco 76710</b>		Operation Mailing Address (City & Zip) <b>P. O. Box 3367, Waco 76707</b>	County <b>McLennan</b>

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 checked="" 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 checked="" 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 checked="" type="checkbox"/> Caregiver <input type="checkbox"/> Director <input type="checkbox"/> Foster parent <input type="checkbox"/> Household Member <input type="checkbox"/> Licensed Administrator <input type="checkbox"/> Other Staff <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer <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			

<b>DFPS Use Only</b>	Worker Name--Last, first	Mail Code
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