**APPLICATION FOR EMPLOYMENT**

*“Under Maryland Law, an Employer may not require or demand, as a condition of employment, prospective employment, or continued employment, that an individual submit to or take a Lie Detector or similar test. An employer who violates this law is guilty of a misdemeanor and subject to a fine not exceeding $100.”*

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

Note: Incomplete and/or applications that are not legible will not be accepted.

**(PLEASE PRINT** IN **CAPITAL LETTERS)**

|  |  |
| --- | --- |
| Position(s) Applied For: **Direct Support Professional**  | Date of Application |
|  |
| Last Name First Name | Middle Name |
| Address Number Street | City State Zip Code |
| Telephone Numbers) : Home: Work:Cellular: | Social Security Number (Full number must be provided) |

Are you currently employed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we contact your present employer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No N/A

If Yes, who is your current employer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you prevented from lawfully becoming employed in this \_\_\_\_Yes \_\_\_\_\_No
country because of Visa or Immigration Status?

(Proof of citizenship or immigration status will be required upon employment)

Do you have a valid driver's license? \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

 Yes No

(If yes, we need a copy of your license after verification)

Do you have a criminal background? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Yes \_\_ No

If yes, please explain. If you need additional space, please use the last page of this application:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Education | Name and Address of School | Course of Study | Years Completed | Diploma or Degree |
| High School |  |  |  |  |
| Other (Specify) |  |  |  |  |

Employment Experience

Start with your present or last job. Include any job-related military service assignments and volunteer activities. You may exclude organizations which indicate race, color, religion, gender, national origin, disabilities or other protected status.

|  |  |  |
| --- | --- | --- |
| (1) Employer | Dates Employed | Work Performed |
| FromMm/yy | ToMm/yy |
| Address: (full) |  |  |  |
| Telephone Number(s)With ext. |  | Hourly Rate/Salary |  |
| Job Title | Supervisor | Starting | Final |  |
|  |  |
| Reason for Leaving |  |  |  |
| (2) Employer | Dates Employed |  |
| Address (full) | FromMm/yy | ToMm/yy |  |
| Telephone NumbersWith ext. |  |  |  |  |
| Job Title | Supervisor | Hourly Rate/Salary |  |
| Reason for leaving |  | Starting | Final |  |
|  |  |

State any additional information you feel may be helpful to us in considering your application.

Note to Applicants: DO NOT ANSWER THIS QUESTION UNLESS YOU HAVE BEEN INFORMED ABOUT THE REQUIREMENTS OF THE JOB FOR WHICH YOU ARE APPLYING.

Are you capable of performing in a reasonable manner, with or without a reasonable accommodation, the activities in the job or occupation for which you applied? A description of the activities involved in such a job or occupation is attached.

Yes No

**DSP Emergency Contact Information:**

In Case of Emergency Notify:

**First Contact**

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Second Contact**

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*In case of emergency, I instruct Center for Community Inclusion to contact the above listed persons. In case of emergency Center for Community Inclusion can release whatever information is necessary to the appropriate medical authority.*

**Professional Reference Contacts**

|  |  |
| --- | --- |
| 1. Full Legal Name of Referee: |   |
| Name of the Company: Phone number:  |
| 2. Full Legal Name of Referee: |  |
| Name of the Company: Phone number:  |
| 3. Full Legal Name of Referee: |  |
| Name of the Company: Phone number:  |

**\* You must present three professional References before you will be authorized to start work.**

**All (3) references should be from your past employer/s. If this is your first employment, we would require reference from your college/school officials, volunteer positions co-workers/managers, anyone else you provided services for in the past.**

I fully authorize the Referees to provide CCI, Inc. with information requested.

I certify that answers given herein are true and complete to the best of my knowledge.

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at the time.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an "at will" nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause. It is further understood that this "at will" employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the employer.

Signature of Applicant:

Date:

**Employment Reference Form 1**

(To be completed by Referee)

Full Legal Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Legal Name of Referee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby attest to the Applicant’s ability to deliver the supports/services for Intellectually Disabled Individuals the Applicant will be serving through his/her Employment with CCI, Inc. to be in full compliance with the applicable MDH/DDA Policies and Values; the Department’s Values in Annotated Code of Maryland, Health General, Title 7. I attest that the Applicant (DSP Staff) will be able to meet all qualifications as outlined in relevant Policies and as outlined in the approved DDA Medicaid Waiver Program Application at the time-of-service delivery.

Signature of Referee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number of Referee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment Reference Form 2**

(To be completed by Referee)

Full Legal Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Legal Name of Referee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby attest to the Applicant’s ability to deliver the supports/services for Intellectually Disabled Individuals the Applicant will be serving through his/her Employment with CCI, Inc. to be in full compliance with the applicable MDH/DDA Policies and Values; the Department’s Values in Annotated Code of Maryland, Health General, Title 7. I attest that the Applicant (DSP Staff) will be able to meet all qualifications as outlined in relevant Policies and as outlined in the approved DDA Medicaid Waiver Program Application at the time-of-service delivery.

Signature of Referee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number of Referee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment Reference Form 3**

(To be completed by Referee)

Full Legal Name of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Legal Name of Referee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby attest to the Applicant’s ability to deliver the supports/services for Intellectually Disabled Individuals the Applicant will be serving through his/her Employment with CCI, Inc. to be in full compliance with the applicable MDH/DDA Policies and Values; the Department’s Values in Annotated Code of Maryland, Health General, Title 7. I attest that the Applicant (DSP Staff) will be able to meet all qualifications as outlined in relevant Policies and as outlined in the approved DDA Medicaid Waiver Program Application at the time-of-service delivery.

Signature of Referee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number of Referee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_