SKILLS DEVELOPMENT SERVICES, INC.

(Revised for 11/05/2014)

APPLICATION FOR EMPLOYMENT

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APPLICATION WILL BE HELD FOR 90 DAYS.

PLEASE FILL OUT ALL INFORMATION AND PRINT CLEARLY!

Last Name, First Name, Middle Name			Maiden Name	Social Security Number
Other Name Used	Driver's License Number	State of Issue	Expiration Date	Position Applied For/ Date Available
Current Address (Street, City, State, Zip Code)		Primary Telephone Number		Secondary Telephone Number

HOME/MAILING ADDRESSES FOR PAST 10 YEARS – PLEASE PUT PRESENT ADDRESS ON LINE 1.

Street Address	City	State	Zip	County	From Mo/Yr	To Mo/Yr
1.						
2.						
3.						
4.						

EMPLOYMENT HISTORY

Show all employment, beginning with last, or present employer. Please attach a resume or list of employers if more room is needed.
If self-employed, list at least 2 businesses and/or contact names, checking the appropriate boxes.

MAY YOUR CURRENT EMPLOYER(S) BE CONTACTED? Yes ☐ No ☐

DATES : Month & Year	
From:	Check One: Employer: ☐ Self Employed - Business Reference ☐ Credit Reference ☐ NAME ____________________ Telephone # __________ ADDRESS: ____________________ CITY __________ STATE ____ ZIP ________ JOB TITLE(S) ____________________
To:	NAME OF SUPERVISOR OR CONTACT: ____________________ DEPT. ________ REASON FOR LEAVING: ____________________
From:	Check One: Employer: ☐ Self Employed - Business Reference ☐ Credit Reference ☐ NAME ____________________ Telephone # __________ ADDRESS: ____________________ CITY __________ STATE ____ ZIP ________ JOB TITLE(S) ____________________
To:	NAME OF SUPERVISOR OR CONTACT: ____________________ DEPT. ________ REASON FOR LEAVING: ____________________
From:	Check One: Employer: ☐ Self Employed - Business Reference ☐ Credit Reference ☐ NAME ____________________ Telephone # __________ ADDRESS: ____________________ CITY __________ STATE ____ ZIP ________ JOB TITLE(S) ____________________
To:	NAME OF SUPERVISOR OR CONTACT: ____________________ DEPT. ________ REASON FOR LEAVING: ____________________
From:	Check One: Employer: ☐ Self Employed - Business Reference ☐ Credit Reference ☐ NAME ____________________ Telephone # __________ ADDRESS: ____________________ CITY __________ STATE ____ ZIP ________ JOB TITLE(S) ____________________
To:	NAME OF SUPERVISOR OR CONTACT: ____________________ DEPT. ________ REASON FOR LEAVING: ____________________

EMERGENCY CONTACT

In the event of emergency at work, please provide name, relationship, number of who to contact.

NAME: ____________________ Relationship: ________________ Phone #: ______________

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Please answer the following:

Have you been convicted of any crime with the past ten years? No ☐ Yes ☐ If so, please complete:

County _____ City _____ State _____ Date _____

Charge: _____ Disposition: _____

Are you legally eligible for employment in this country? Yes ☐ No ☐

I certify and affirm that to the best of my knowledge and belief I have *OR* I have not had (circle one) **or received a finding of a substantiated case of abuse, neglect, mistreatment or exploitation against me by the Department of Intellectual and Developmental Disabilities (DIDD). In order to verify this affirmation, I further release and authorize Skills Development Services, Inc., DIDD and the Bureau of TennCare to have full and complete access to any and all current or prior personnel or investigative records as pertains to any substantiated allegations against me of abuse, neglect, mistreatment or exploitation.**

SIGNATURE: _____ DATE: _____

EDUCATION HISTORY (most recent first)		
Did you graduate high school or receive a G.E.D.? Yes ☐ No ☐		
School Name and Address	**Major (if applicable)**	**Type of Degree**

OTHER LICENSES OR CERTIFICATIONS			
Type of License or Certification	**License or Certificate Number**	**State of Issue**	**Expiration Date**

PERSONAL REFERENCES:

Please provide the name of two persons who are local (***not family***), whom you have known one year or longer, with **one person you have known for 5 years or longer**. ***DO NOT LIST EMPLOYERS***.

Name	**Address and Telephone Number**	**Business**	**Years Acquainted**

Skills Development Services, Inc. **is committed to a drug free workplace**. All job applicants and employees are subject to drug screening. Illegal use or possession of Drugs or Alcohol **may lead** to denial of employment, termination and/or loss of workers' compensation benefits!

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed; falsified statements on this application shall be grounds for dismissal. I authorize investigation of all statements contained herein and the references listed above to give you any and all information concerning my previous employment and any pertinent information they may have, and release all parties from all liability for any damage that may result from furnishing same to you. I understand and agree that, if hired, my employment is for no definite period of time and termination of employment can happen without prior notice and without cause.

I hereby consent to submit to urinalysis and/or other tests as shall be determined by Skills Development Services, Inc. in the selection process of applicants for employment or during random testing of employees, for the purpose of determining the drug content thereof.

I consent that SPECTRUM MEDICAL ASSOCIATES may collect specimens for these tests and may test them or forward them to a testing laboratory designated by the company for analysis. I further agree to and hereby authorize the release of the results of said tests to Skills Development Services, Inc. I understand that it is the current illegal use of drugs that prohibits me from being employed at Skills Development Services, Inc. I further agree to hold harmless Skills Development Services, Inc. and its agents (including the above named physician or clinic) from any liability arising in whole or part out of the collection of specimens, testing, and use of the information from said testing in connection with Skills Development Services, Inc. consideration of my employment application.

I have read the foregoing and understand its contents. I acknowledge that my signing of this form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

DATE: _____ SIGNATURE: _____ SS # _____

I (do/do not) give permission to release reference information regarding my employment with Skills Development Services, Inc.

Employee's Signature	Date
Supervisor's Signature	Date

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DO NOT WRITE IN THIS SPACE - FOR OFFICE USE ONLY

Applicant's name: _____

Interviewed by: _____ Date: _____

Remarks: _____

_____

Hired: _____ Position: _____ Program: _____

Date Reporting to Work: _____

Approved by: _____ _____

Immediate Supervisor Personnel Supervisor

REFERENCE CHECKS

With all reference checks list name of person with whom you spoke and the date.

Supervisor: As per the Provider Manual section 6 – *At a minimum, the provider must directly communicate with the most recent employer and any employer who employed the job applicant for more the 6 months within than the past 5 years.*

Employer Reference: _____

_____

Employer Reference: _____

_____

Employer Reference: _____

_____

Employer Reference: _____

_____

Employer Reference: _____

_____

The provider must directly communicate with the personal references provided by the job applicant with one of the references having known the employee for at least 5 years.

Personal Reference 1: _____

_____

Personal Reference 2: _____

_____