



CENTER ON DEAFNESS

3444 Dundee Road Northbrook IL 60062 - 847/559-0110 TTY 847/559-9493 FAX 847/559-8199

Application for Employment

PERSONAL			
Last Name	First	Middle	
Street Address	Home Phone	Business Phone	
City	State	Zip	Social Security Number
Have you ever applied for employment with us? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, month, year, location:			
Position Desired		Pay Expected	
Are you available to work full time? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, what hours can you work?		When will you be available to begin work?	
How did you learn of our organization?			
Other special training, skills, languages:			
Long range occupational goals:			

If you attach a resume which contains information requested in the Education and Employment sections, you may omit those sections except for areas marked with *.

EDUCATION & CERTIFICATION					
	Name and Location of School	Course of Study	Years Completed	Did you Graduate?	Degree or Diploma
High School					
College					
Graduate Study					
Professional Licenses and/or Certification					
Type	State Issued	Number		Exp. Date	
Type	State Issued	Number		Exp. Date	
Membership in Professional or Civic Organizations (You may exclude those which may disclose your race, color, religion or national origin)					

EMPLOYMENT

Please give accurate, complete full-time and part-time employment for a minimum of five years. Start with present or most recent employer. If resume is attached, please complete only items with *.

1	Company	Telephone		
	Address	Employed (Month/Year)	From	To
	Name of Supervisor <input type="checkbox"/> Please do not contact	Weekly Pay	Start	End
	State Job Title and Describe Your Work	*Reason for Leaving		

2	Company	Telephone		
	Address	Employed (Month/Year)	From	To
	Name of Supervisor <input type="checkbox"/> Please do not contact	Weekly Pay	Start	End
	State Job Title and Describe Your Work	*Reason for Leaving		

3	Company	Telephone		
	Address	Employed (Month/Year)	From	To
	Name of Supervisor <input type="checkbox"/> Please do not contact	Weekly Pay	Start	End
	State Job Title and Describe Your Work	*Reason for Leaving		

4	Company	Telephone		
	Address	Employed (Month/Year)	From	To
	Name of Supervisor <input type="checkbox"/> Please do not contact	Weekly Pay	Start	End
	State Job Title and Describe Your Work	*Reason for Leaving		

PROFESSIONAL REFERENCES

Name & Occupation	Address	Phone Number
1.		
2.		
3.		

Are you a Veteran of the U.S. Military Service? Yes No
 If yes, Branch _____, Type of Discharge _____, Date of Discharge _____

How long at present address? _____ yrs. How long at previous address? _____ yrs.

Have you been convicted of a crime other than a minor traffic violation? Yes No
 If yes, please explain.

Are there workplace changes which would enable you to perform your job better? Yes No
 If yes, please describe the limitation.

Do you have physical, medical or mental impairments which would limit you from performing certain job functions? Yes No If yes, please describe the limitation.

(Optional) Have you had a major illness or injury in the past five years? Yes No
 If yes, please describe.

(Optional) Have you received Worker's Comp. or Disability Income payments? Yes No
 If yes, please explain the circumstances.

I certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given by me 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, including Criminal Background checks. I further understand that if I am offered employment, I will not be allowed to work until I have complied with the requirements of the Immigration and Naturalization Service Employment Eligibility Verification Form (Form I-9). In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge regardless of length of employment. I understand that I am required to abide by the rules and regulations of the Center On Deafness (COD). I understand that nothing contained in this application or conveyed during any interview which may be granted is intended to create any employment contract between me and the Center On Deafness. In addition, I understand and agree that if I am employed, my employment is for no definite or determinable period and may be terminated at any time, with or without prior notice or cause, at the option of either myself or the Center On Deafness, and that no promises or representations contrary to the foregoing are binding on the Center On Deafness. I also understand that if employed I am considered to be on probationary status for at least the first ninety (90) days unless otherwise specified.

 Signature

 Date

Please use this space to write any comments you feel are pertinent to your application.

FOR EMPLOYER'S USE ONLY		
Interviewer Name and Comments		
Reference Checks		
	Person Contacted	Results
Employer 1		
Employer 2		
Employer 3		
Employer 4		

APPLICANT DATA RECORD

Applicants are considered for all positions, and employees are treated during employment without regard to race, color, religion, sex, national origin, marital or veteran status, medical condition or disability.

As employers/government contractors, we comply with government regulations and affirmative action responsibilities.

Solely to help us comply with government record keeping, reporting and other legal requirements, please fill out the Applicant Data Record. We appreciate your cooperation.

The data is periodic government reporting and will be kept in a CONFIDENTIAL FILE separate from the Application for Employment.

Name: Last	First	Middle	Phone
Address: Street	City	State	Zip

(Please Print)

Position(s) applied for _____ Date _____

Referral Source: Advertisement Friend Relative Walk-In
 Employment Agency Other

Affirmative Action Survey

Government agencies require periodic reports on sex, ethnicity, disability and veteran status of applicants. This data is for analysis and affirmative action only. Submission of information about a disability is voluntary.

Check one: Male Female

Check one of the following – Race/Ethnic Group:

Caucasian African American Hispanic/Latino
 Asian/Pacific Islander Native American Other

Center on Deafness Employment Application

Please write your comments to each of the following questions:

1. Are you interested in working with:

- Children Adults No Preference

2. Why are you interested in working at the Center on Deafness?

3. What "strengths" do you bring to this job?

4. In what areas do you want to improve?



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Release of Information

I, the undersigned applicant, authorize the Center on Deafness to check my references and employment history.

I also authorize any former employer or personal reference to respond to the reference form contained on the reverse side of this page.

I also release the Center on Deafness and all providers of information to whom this release is sent, from any liability as a result of furnishing this information.

Applicant

Date

The Center on Deafness is dedicated to providing quality services for persons who are deaf or hard of hearing and their families, through educational, vocational and residential services in a therapeutic, community-based environment.

Accredited by the Joint Commission on Accreditation of Health Care Organizations
Approved by the Illinois State Board of Education