



Where **life** gets a 2nd chance.

APPLICATION FOR EMPLOYMENT

EQUAL OPPORTUNITY EMPLOYER

PERSONAL INFORMATION

NAME(LAST NAME FIRST)		SOCIAL SECURITY NO. ___ ___	
PRESENT ADDRESS	CITY	STATE	ZIPCODE
PERMANENT ADDRESS	CITY	STATE	ZIPCODE
PHONE NO. ()	REFERRED BY		

EMPLOYMENT DESIRED

POSITION	DATE YOU CAN START	SALARY
ARE YOU EMPLOYED? ___YES ___NO	IF SO, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? ___YES ___NO	
EVER APPLIED TO THIS COMPANY BEFORE? ___YES ___NO	WHERE?	WHEN?

EDUCATION HISTORY

NAME & LOCATION OF SCHOOL	YEARS ATTENDED	DID YOU GRADUATE?	SUBJECTS STUDIED
GRAMMAR SCHOOL			
HIGH SCHOOL			
COLLEGE			
TRADE, BUSINESS OR CORRESPONDENCE SCHOOL			

GENERAL INFORMATION

SUBJECTS OF SPECIAL STUDY/RESEARCH WORK OR SPECIAL TRAINING/SKILLS	
U.S. MILITARY OR NAVAL SERVICE	RANK

FORMER EMPLOYERS (LIST BELOW LAST FOUR EMPLOYERS, STARTING WITH LAST ONE FIRST)

DATE MONTH & YEAR	NAME & ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
FROM TO				
FROM TO				
FROM TO				
FROM TO				

REFERENCES GIVE BELOW THE NAMES OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST A YEAR,

NAME	ADDRESS	BUSINESS	YEARS KNOWN

AUTHORIZATION

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 and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information.

I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative.

This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the Americans with Disabilities Act (ADA) and other relevant federal and state laws."

Date _____

Signature _____