



# Cheney Care Center Employment Application



<b>APPLICANT INFORMATION</b>			
Last Name:	First:	M.I.	Date:
Street Address:		Apartment/Unit #:	
City:	State:	ZIP:	
Phone No.:	E-mail Address:		
Date Available:		Desired Salary:	
Position Applied for:			
Are you able to provide proof of your ability to work in the United States?      YES [ ]    NO [ ]			
Have you ever worked for this company?    YES [ ]    NO [ ]		If yes, when?	
Do you have any responsibilities or commitments that may prevent you from meeting work and attendance requirements?			
Where did you hear about Cheney Care Center?			
<b>WORK DESIRED</b>			
What prompted you to apply for a position with us?			
Can you rotate shifts? YES [ ]    NO [ ]			
Full Time [ ]	Part Time [ ]	Any Shifts [ ]	Days [ ]    Evenings [ ]    Night Shift (NOC) [ ]
<b>EDUCATION</b>			
<b>High School:</b>		City/State	
Did you graduate? YES [ ]    NO [ ]		Degree:	
<b>College:</b>		Address:	
From	To	Did you graduate? YES [ ]    NO [ ]	Degree:
<b>Other:</b>		Address:	
From	To	Did you graduate? YES [ ]    NO [ ]	Degree:
<b>PROFESSIONAL REGISTRATION OR CERTIFICATION</b>			
<i>If you do not have a required registration or license, have you applied for one?      YES [ ]      NO [ ]</i>			
Human Resources Only	<u>Type of registration or certificate</u>	<u>State</u>	<u>Number</u>

**EMPLOYMENT HISTORY**

List all employers beginning with your present/most recent employer, then previous employers in order, attach a separate sheet or resume if you have had more than four employers.

<b>Company:</b>		Phone:	
Address:		Supervisor:	
Job Title:	Starting Salary:	Ending Salary:	
Responsibilities:			
From:	To:	Reason for Leaving:	
May we contact your previous supervisor for a reference? YES [ ] NO [ ]			
<b>Company:</b>		Phone:	
Address:		Supervisor:	
Job Title:	Starting Salary:	Ending Salary:	
Responsibilities;			
From:	To:	Reason for Leaving:	
May we contact your previous supervisor for a reference? YES [ ] NO [ ]			
<b>Company:</b>		Phone:	
Address:		Supervisor:	
Job Title:	Starting Salary:	Ending Salary:	
Responsibilities:			
From:	To:	Reason for Leaving:	
May we contact your previous supervisor for a reference? YES [ ] NO [ ]			
<b>Company:</b>		Phone:	
Address:		Supervisor:	
Job Title:	Starting Salary:	Ending Salary:	
Responsibilities:			
From:	To:	Reason for Leaving:	
May we contact your previous supervisor for a reference? YES [ ] NO [ ]			
Describe your work experience?			
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What would you like to be doing in five years?

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What type of work do you find to be most interesting?

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What type of work do you dislike most?

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Cheney Care Center/Cheney Assisted Living/Cheney Home Care does not discriminate in employment opportunities or practices on the basis of race, color, religion, sex, sexual orientation, national origin, age disability, marital status, veteran status, or any other characteristic protected by law. Cheney Care Center/Cheney Assisted Living/Cheney Home Care is an Equal Opportunity/Affirmative Action Employer.

**REFERENCES**

*Please list four professional adult references, Not related to you*

<b>Full Name:</b>	Years Known:	Email Address:
Company:	Phone No.:	
Address:		
<b>Full Name:</b>	Years Known:	Email Address:
Company:	Phone No.:	
Address:		
<b>Full Name:</b>	Years Known:	Email Address:
Company:	Phone No.:	
Address:		

Additional information about you which would aid us in our employment decision? \_\_\_\_\_

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**DISCLAIMER AND SIGNATURE**

I hereby certify that the information contained on this application form is true, accurate and my complete employment history. I authorize Cheney Care Center/Cheney Assisted Living/Cheney Home Care to contact any of my schools or former employers, except those I have indicated, for a complete account of their experience with me. I understand that if I am employed, any misrepresentation of facts on this application or during the interview is sufficient cause for dismissal. I also understand that I must successfully complete any medical tests/examinations that are required by Cheney Care Center/ Cheney Assisted Living/ Cheney Home Care. I also understand that, regardless of personal preference, I might be called upon to rotate to a different shift should the needs of the facility require a change.

Signature:	Date:
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# CHENEY CARE CENTER



2219 North 6<sup>th</sup> St.  
Cheney, WA 99004-2199  
(509)235-6196 (509)235-2044 Fax

## Reference Request

Attention: \_\_\_\_\_

Name: \_\_\_\_\_ has applied to our facility for employment. Please complete the appropriate section below and fax back to us at your earliest convenience. Your prompt attention is appreciated. Thank you.

Position Held: \_\_\_\_\_ Dates Employed: From \_\_\_\_\_ to \_\_\_\_\_

### Release:

I hereby release from all liability the company or the person completing this form, and authorize them to release all information regarding my fitness for employment to Cheney Care Center. I understand that I may revoke this authorization, in writing, at any time. I also understand that I may not maintain an action against the person, institution, company or entity or any other person giving information in good-faith reliance on an authorization without actual notice of the revocation of the authorization.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employment Reference: Is the above employment information correct?

Yes \_\_\_\_\_ No \_\_\_\_\_ (If no, please explain.) \_\_\_\_\_

	Above Average	Average	Below Average
Job Knowledge	[ ]	[ ]	[ ]
Cooperation	[ ]	[ ]	[ ]
Dependability, Attendance	[ ]	[ ]	[ ]
Quality of Care	[ ]	[ ]	[ ]
Getting along with others	[ ]	[ ]	[ ]
Would you rehire this person? Yes [ ] NO [ ] (If no, please explain.)			

Other information: \_\_\_\_\_

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

Title/or Relationship to Applicant: \_\_\_\_\_

## APPLICANT VOLUNTARY SELF-IDENTIFICATION INFORMATION

As a federal government contractor, we are requesting information about race, gender, and veteran status in order to comply with government reporting requirements and in order to ensure equal employment opportunity. We consider all applicants for positions without regard to their race, color, religion, sex, sexual orientation, gender identity, or national origin. We also comply with all applicable laws including E.O. 11246, as amended, and the Vietnam Era Veterans Readjustment Assistance Act of 1974, as amended (VEVRAA), governing employment practices and do not discriminate on the basis of any unlawful criteria.

In an effort to comply with requirements regarding government recordkeeping, reporting, and other legal obligations, which may apply, we invite you to complete this applicant data survey. Submission of this information is voluntary and will be kept confidential. Failure to provide information will not subject you to any adverse personnel decision or action. Your cooperation is appreciated.

Position: \_\_\_\_\_

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

### **GENDER**

MALE                       FEMALE                       I DECLINE TO ANSWER

### **RACE/ETHNICITY**

WHITE (not Hispanic or Latino)

HISPANIC OR LATINO

BLACK or AFRICAN AMERICAN (not Hispanic or Latino)

ASIAN (not Hispanic or Latino)

NATIVE HAWAIIAN or PACIFIC ISLANDER (not Hispanic or Latino)

AMERICAN INDIAN/ALASKA NATIVE (not Hispanic or Latino)

TWO or MORE RACES (not Hispanic or Latino)

I DECLINE TO ANSWER

### **VETERANS STATUS**

This company is also subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, [38 U.S.C. 4212](#) (VEVRAA), which requires Government contractors to take affirmative action to employ and advance in employment veterans in the following classifications:

- A "disabled veteran" is one of the following:
  - a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or
  - a person who was discharged or released from active duty because of a service-connected disability.
- A "recently separated veteran" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.
- An "active duty wartime or campaign badge veteran" means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.
- An "Armed forces service medal veteran" means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to [Executive Order 12985](#).

If you believe you belong to any of the categories of protected veterans listed above, please indicate by checking the appropriate box below. As a Government contractor subject to VEVRAA, we request this information in order to measure the effectiveness of the outreach and positive recruitment efforts we undertake pursuant to VEVRAA.

I IDENTIFY AS ONE OR MORE OF THE CLASSIFICATIONS OF PROTECTED VETERAN LISTED ABOVE

I AM NOT A PROTECTED VETERAN

I DECLINE TO ANSWER

# Voluntary Self-Identification of Disability

THIS WORDING IS REQUIRED BY THE US GOVERNMENT:

## Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.<sup>1</sup> To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

## How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

### PLEASE CHECK ONE OF THE BOXES BELOW:

- YES, I HAVE A DISABILITY (or previously had a disability)
- NO, I DON'T HAVE A DISABILITY
- I DON'T WISH TO ANSWER

Your Name

Today's Date

\_\_\_\_\_

\_\_\_\_\_

## REASONABLE ACCOMMODATION NOTICE

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

<sup>i</sup> Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at [www.dol.gov/ofccp](http://www.dol.gov/ofccp).

**PUBLIC BURDEN STATEMENT:** According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.