

VIP

## VOCATIONAL INDEPENDENCE PROGRAM

## Application for Employment

This Company is an equal opportunity employer and will not discriminate against any applicant on the basis of any characteristic that is protected by State or Federal law.

Position Applied For: \_\_\_\_\_ Date of Application: \_\_\_\_\_

Date You Can Start: \_\_\_\_\_

Please note that this application will only remain active for 3 months, after which the applicant would need to re-apply.

Name: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_  
Last First M.I.

Present Address: \_\_\_\_\_  
Street City State Zip

Permanent Address: \_\_\_\_\_  
Street City State Zip

Telephone #: Home (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_

Are you 18 years or older? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are there any hours or days of the week you cannot work? \_\_\_\_\_ If so, when? \_\_\_\_\_

Salary Desired: \_\_\_\_\_ Type of Employment: \_\_\_\_\_ Full-time \_\_\_\_\_ Part-time

Are you employed now? \_\_\_\_\_ May we contact your present employer? \_\_\_\_\_

Name, title and phone of current employer: \_\_\_\_\_

Have you ever applied to this Company before? \_\_\_\_\_ Where? \_\_\_\_\_

Under what name? \_\_\_\_\_ When? \_\_\_\_\_

## EDUCATION:

	Name and Location of School	No. of Years Attended	Did You Graduate?	Subject/Major
Elementary School				
High School				
College				
Specialized Training				

Do you have US Military experience? \_\_\_\_\_ Date Entered: \_\_\_\_\_

Branch: \_\_\_\_\_ Rank: \_\_\_\_\_ Date Discharged: \_\_\_\_\_ Honorably? \_\_\_\_\_

Are you lawfully entitled to be employed in the United States? \_\_\_\_\_



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Have you ever been convicted of a crime except a minor traffic violation? \_\_\_\_\_ No \_\_\_\_\_ Yes  
If so, please state citation, date and place where offense occurred. \_\_\_\_\_

\_\_\_\_\_  
Please provide any additional information such as special skills, training, management experience, equipment operation or qualifications you feel will be helpful to us in considering your application.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**REFERENCES:** Three individuals not related to you, whom you have known for at least one year:

Name	Address and Telephone	Relationship	Years Acquainted

Emergency Contact: \_\_\_\_\_  
Name Street City/State Phone

**CURRENT AND FORMER EMPLOYERS: (Most Recent First)**

Date Month/Year	Employer Name, Address, and Telephone	Salary Starting/ Ending	Last Position Held/ Responsibilities	Reason for Leaving
From:  To:				
From:  To:				
From:  To:				
From:  To:				
From:  To:				



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May we contact the employers listed? \_\_\_\_\_ Yes \_\_\_\_\_ No

If not, which one(s)? \_\_\_\_\_

Please read the following statement carefully before signing to indicate your understanding.

I understand that, prior to being offered employment, I may be requested to take an employment examination. In the event that I have a disability that will affect my ability to take the test, I will so inform the Company prior to the test so that a reasonable accommodation can be made. The Company reserves the right to require medical documentation regarding the need for accommodation.

I certify that the facts contained in this application are true, accurate, and complete to the best of my knowledge and understand that, if employed, falsified statements or omitted material facts on this application may result in my disqualification from consideration for employment, or termination from employment if I have been hired.

I authorize investigation of all statements contained in this application for any employment-related purpose. I release the listed references and all employers, except those specifically excepted,\* to provide you with any and all applicable information they may have. I hereby release these references and former employers from all liability for any information they may give to the Company.

As a condition of employment, I agree not to commence any action or suit relating to my employment relationship with the Company more than 301 calendar days after the date of termination of employment or in the time prescribed by the applicable statute, whichever is less. Further, I agree to waive any statute of limitation exceeding 301 days.

Any employment relationship with this organization is of a "just cause" nature.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\* Employers specifically excepted: \_\_\_\_\_

**For Employer Use Only**

Interviewed By: \_\_\_\_\_ Date: \_\_\_\_\_ Hired: \_\_\_\_\_ Yes \_\_\_\_\_ No

Starting Date: \_\_\_\_\_ Position: \_\_\_\_\_ Wage: \_\_\_\_\_



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#### AUTHORIZATION TO DISCLOSE EMPLOYEE INFORMATION AND RELEASE OF LIABILITY

I, \_\_\_\_\_, authorize Genesee Health System (GHS) and the GHS Office of Recipient Rights  
(print full name)  
to disclose to the Provider/Consumer listed below any and all information in your possession regarding any violation of recipients' rights committed by me. I recognize that any disclosure cannot include confidential client information protected by any Federal, State, or common law.

I, \_\_\_\_\_, release GHS and the GHS Office of Recipient Rights, its officers, its agents and its  
(print full name)  
employees from any and all liability, claims, suits, and actions of any nature brought against GHS and the GHS Office of Recipient Rights, its officers, its agents and its employees etc. for disclosing the information requested by me and I shall indemnify and hold them harmless should any claims, suits or actions be filed against them.

#### PREVIOUS PLACES OF EMPLOYMENT:

1. \_\_\_\_\_ Dates employed: \_\_\_\_\_ to \_\_\_\_\_  
2. \_\_\_\_\_ Dates employed: \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Other names used

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

#### INFORMATION TO BE SENT TO: Vocational Independence Program

\_\_\_\_\_  
Provider/Consumer  
5069 Van Slyke Rd

\_\_\_\_\_  
Street Address  
Flint, MI 48507 (810) 238-2140

\_\_\_\_\_  
City State Zip Code FAX

Fax this form to: (810) 257-3790 for processing

#### RIGHTS OFFICE USE ONLY

An individual with the above name does have a substantiated recipient rights violation(s) according to GHS records.

By: \_\_\_\_\_

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

**GHS Office of Recipient Rights**



**VOCATIONAL INDEPENDENCE PROGRAM**  
**Authorization for Background Check**

The position you currently have with Vocational Independence Program requires that we obtain a consumer, and/or investigative consumer report. Therefore, we may obtain a report on the status of your driving record, and/or criminal record check. We may use either or both reports in making employment decisions related to your position. It is Vocational Independence Program's policy to consider any and all information available that is relevant to an employee's suitability and qualifications for their position.

Further information on the nature and scope of these reports will be made available to you within 30 days of when you make a written request. Before taking any adverse employment action based on either of these reports, we will provide you with a copy of the report.

Name: \_\_\_\_\_  
*Please Print: Last, First, Middle*

Other Names Used: \_\_\_\_\_  
*Alias, Maiden, etc.*

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I authorize Vocational Independence Program to investigate my personal history, character, educational and training records, employment records, driving record and criminal history, as they may be relevant to determine my suitability for employment with Vocational Independence Program. A photocopy of this signed authorization will carry the same effect as the original. This authorization expires 12 months from the date below.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

