Office use only - Application #:_____

APPLICATION FOR EMPLOYMENT

Application Date: _____

Position(s) Interested In:

_____ Office/specialized area
_____ Job Coach/Supportive Employment
_____ Tomah Day Center & personal cares
_____ Rest Area/Janitorial
_____ Case Management/specialized area
_____ Production/Work skills training
_____ Sparta Day Center & personal cares

Type of employment desired: _____ Full Time _____ Part Time _____ Temp or Seasonal

Referral Source: _____ Advertisement _____ Walk-in _____ Website
_____ Current Employee- Name of Employee: _____

==========

NAME: _____
Last First Middle

Address: _____
Street City State Zip Code

Telephone Number: _____ Email address: _____
Including Area Code if you wish to be contacted through email

If you are under 18, can you furnish a work permit?: ____Yes ____No

Have you filed an application here before?: ____Yes ____No If yes, give date: _____

Have you ever been employed here before?: ____Yes ____No If yes, give date: _____
From To

Are you legally eligible for employment in this country?: ____Yes ____No
(Proof of U.S. Citizenship or immigration status will be required upon employment)

AN EQUAL OPPORTUNITY EMPLOYER

EMPLOYMENT HISTORY

Employer (1)		Job Title	Dates Employed
Work Phone	Address	City	State/Zip
Reason for leaving			
Summarize Job & Responsibilities:			

Employer (2)		Job Title	Dates Employed
Work Phone	Address	City	State/Zip
Reason for leaving			
Summarize Job & Responsibilities:			

Employer (3)		Job Title	Dates Employed
Work Phone	Address	City	State/Zip
Reason for leaving			
Summarize Job & Responsibilities:			

Employer (4)		Job Title	Dates Employed
Work Phone	Address	City	State/Zip
Reason for leaving			
Summarize Job & Responsibilities:			

EDUCATIONAL BACKGROUND (if job related)				
School Name	**Number of Years completed**	**Degree/Diploma**	**Major**	**Minor**

Skills and Qualifications: Summarize special skills and qualifications acquired from employment or other experiences that may qualify you to be successful with our company.

_____

_____

_____

_____

_____

_____

_____

Comments and any additional information you would like us to consider (including explanation of any gaps in employment):

_____

_____

_____

_____

_____

_____

_____

It is understood and agreed upon that any misrepresentation by me in this application will be sufficient cause for cancellation of this application and/or separation from the employer's service if I have been employed. I give the Employer the right to investigate all references and to secure additional information about me, if job related. I hereby release from liability the Employer and its representatives for seeking such information and all other persons, corporations or organizations for furnishing such information.

The Employer is an Equal Opportunity Employer. The Employer does not discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant's consideration for employment on a basis prohibited by local, state, or federal law.

This application will be kept on file for a period of two years and I will be considered for positions as they come available. At the conclusion of this time, if I have not heard from the Employer and still wish to be considered for employment, it will be necessary to fill out a new application.

I understand that just as I am free to resign at any time, the Employer reserves the right to terminate my employment at any time, with or without cause and without prior notice. I understand that no representative of the Employer has the authority to make any assurances to the contrary.

Signature of Applicant: _____ Date: _____

Returning Applications:

Mail or Drop Off:
Handishop Industries, Inc.
1411 North Superior Ave
Tomah, WI 54660

Email:
handishop@handishop.org

Ajt 9/19

HANDISHOP INDUSTRIES, INC.
AFFIRMATIVE ACTION INFORMATION

It is the policy of Handishop Industries to maintain and promote employment opportunities to all individuals without regard to race, handicap, gender, age, creed, or national origin and to promote that policy through a positive continuing program to be known as Handishop Industries Affirmative Action Program.

To help us comply with Federal/State equal employment opportunity record keeping reporting and other legal requirements, please answer the questions below.

Completion of this form is voluntary.

NAME (print): _____
Last First Middle

POSITION APPLIED FOR: _____ DATE: _____

RACE/ETHNIC GROUP: ( ) WHITE ( ) BLACK ( ) HISPANIC
( ) ASIAN/PACIFIC ISLANDER
( ) AMERICAN INDIAN/ALASKA NATIVE

GENDER: ( ) MALE ( ) FEMALE

MILITARY SERVICE: ( ) NONE ( ) VETERAN
( ) VIETNAM ERA VETERAN

This Affirmative Action form will be kept in a Confidential File separate from the personal files.

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 05/31/2023

Name: _____ Date: _____

Employee ID: _____
(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you 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:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

Please check one of the boxes below:

☐ Yes, I Have A Disability, Or Have A History/Record Of Having A Disability

☐ No, I Don't Have A Disability, Or A History/Record Of Having A Disability

☐ I Don't Wish To Answer

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.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.

For example:

Job Title: _____ Date of Hire: _____