

Office use only - Application #: \_\_\_\_\_



# Handishop Industries Application for Employment

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

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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

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|  |  |
|--|--|
| <b>Position(s) Interested In:</b>  |  |
| Day Center: <input type="checkbox"/> Tomah <input type="checkbox"/> Sparta | Rest Area- Sparta: <input type="checkbox"/> Lead <input type="checkbox"/> Attendant  |
| <input type="checkbox"/> Office  | Rest Area- Mauston: <input type="checkbox"/> Lead <input type="checkbox"/> Attendant |
| <input type="checkbox"/> Job Coach   | Rest Area- Black River Falls: <input type="checkbox"/> Lead                          |
| <input type="checkbox"/> Community Employment Specialist                   | <input type="checkbox"/> Attendant   |

|  |
|--|
| <b>Type of employment desired:</b> <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time |
|--|

|   |
|---|
| <b>Referral Source:</b> <input type="checkbox"/> Advertisement <input type="checkbox"/> Walk-in <input type="checkbox"/> Internet |
| <input type="checkbox"/> Current Handishop Employee: Name of Employee: _____  |

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### **AN EQUAL OPPORTUNITY EMPLOYER**

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: \_\_\_\_\_

## 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: |         |                |                |
|                                   |         |                |                |
|                                   |         |                |                |

## EDUCATIONAL BACKGROUND (highest level of education)

| School Name<br>Years | Degree/Diploma completed | Major | Minor |
|----------------------|--------------------------|-------|-------|
|                      |                          |       |       |

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

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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 04/30/2026

Name: \_\_\_\_\_  
Employee ID: \_\_\_\_\_  
(if applicable)

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

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

We are a federal contractor or subcontractor. The law requires us to provide equal employment opportunity to qualified people with disabilities. We have a goal of having at least 7% of our workers as people with disabilities. The law says we must measure our progress towards this goal. To do this, we must ask applicants and employees if they have a disability or have ever had one. People can become disabled, so we need to ask this question at least every five years.

Completing this form is voluntary, and we hope that you will choose to do so. Your answer is confidential. No one who makes hiring decisions will see it. Your decision to complete the form and your answer will not harm you in any way. If you want to learn more about the law or this form, 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).

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

A disability is a condition that substantially limits one or more of your "major life activities." If you have or have ever had such a condition, you are a person with a disability. **Disabilities include, but are not limited to:**

- Alcohol or other substance use disorder (not currently using drugs illegally)
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, HIV/AIDS
- Blind or low vision
- Cancer (past or present)
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or serious difficulty hearing
- Diabetes
- Disfigurement, for example, disfigurement caused by burns, wounds, accidents, or congenital disorders
- Epilepsy or other seizure disorder
- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome
- Intellectual or developmental disability
- Mental health conditions, for example, depression, bipolar disorder, anxiety disorder, schizophrenia, PTSD
- Missing limbs or partially missing limbs
- Mobility impairment, benefiting from the use of a wheelchair, scooter, walker, leg brace(s) and/or other supports
- Nervous system condition, for example, migraine headaches, Parkinson's disease, multiple sclerosis (MS)
- Neurodivergence, for example, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, dyslexia, dyspraxia, other learning disabilities
- Partial or complete paralysis (any cause)
- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
- Short stature (dwarfism)
- Traumatic brain injury

### 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: \_\_\_\_\_

