COUNCIL ON AGING OF ST. LUCIE, INC.
Application for Employment

Position Desired____________________________
Date_____________________________________

AN EQUAL OPPORTUNITY EMPLOYER. Please answer all questions. Incomplete applications may not be considered. Please PRINT all information.

LAST NAME FIRST NAME MIDDLE INITIAL

STREET ADDRESS CITY, STATE ZIP

TELEPHONE NUMBER

EDUCATIONAL DATA

School	Address	No. of Yrs. Completed	Degree	Major Course of Study
High School				
College				
Graduate School				
Vocational, Trade School				
Other				

List any other job-related skills, educational experience or qualifications that support your application:
____
____

Honors Received: ____
____

If offered employment, can you submit documentation verifying your eligibility to work in the U.S.?
_______ Yes ________ No

Are you over 18 years of age? _____Yes _____ No

In order to permit a check of your work and educational records, please identify any changes of name or assumed names that you have previously used and relevant dates.
____

Have you ever been convicted of a felony? ______ Yes _____ No If yes, please list dates and explain. Attach a separate sheet if necessary. A conviction will not necessarily disqualify you from employment. CRIMINAL HISTORY WILL BE CHECKED UPON HIRE.

EMPLOYMENT EXPERIENCE

Please list all former employers, with the most recent first. Account for all time periods, including unemployment, self-employment and military service. Please attach additional sheets if necessary.

Employer	Telephone No.	Work Performed
Address	Start Date	
	End Date	
Job Title	Starting Salary	
Immediate Supervisor	Ending Salary	
Reason for Leaving	May we Contact?	

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Please explain any reasons for not contacting prior employers: ____

____

____

Do you currently hold any licenses / certifications that relate to the position? _______ Yes ______No If yes, please list names of licenses / certifications and issuing state.

Are you currently employed? _______ Yes _______ No
Are you on layoff? ______ Yes ______ No Are you subject to recall? _____ Yes _____ No

Have you ever been discharged or forced to resign from any employment? ______ Yes ______ No If yes, please explain:

Do you have transportation to work? ____Yes ____ No
Will you work overtime if asked? ___ Yes ____ No
Are there any hours, shifts or days you will not work? ______ Yes ______ No If yes, please explain:

____

____

Do you have any friends or relatives who work at Council on Aging? ______ Yes ______ No	
Name	Relationship
Name	Relationship
Name	Relationship

Character References
Please list three persons not related to you, whom you have known at least one year.

Name	Occupation
Address	Telephone

Name	Occupation
Address	Telephone

Name	Occupation
Address	Telephone

List below any other information or remarks that you wish to have considered as a part of your application for employment.

____

____

____

Some of our clients may not speak English. Do you speak, write, or understand any foreign languages?
______ Yes ______ No If yes, which languages?

If hired, when can you start?

NOTICE TO APPLICANTS: COASL complies with the Americans with Disabilities Act of 1990. During the interview process, you may be asked questions concerning your ability to perform job-related functions. If you are given a conditional offer of employment, you may be required to complete a post-job offer medical history questionnaire and / or undergo a medical examination. If required, all entering employees in the same job category will be subject to the same medical questionnaire and / or examination and all information will be kept confidential and in separate files.

COASL is an Equal Opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, age, religion, national origin, disability or marital status. We assure you that your opportunity for employment at COASL depends solely on you qualifications.

COASL is a Substance-Free Workplace. All new employees will be required to undergo breath or urinalysis screening for drug or alcohol use.

APPLICANT'S STATEMENT

I certify that the information given herein is true and complete to the best of my knowledge. I authorize the investigation of all matters concerned in this application and hereby give COASL permission to contact schools, previous employers, references and others, and hereby release COASL from any liability as a result of such.

I further authorize my former employers to disclose to COASL any and all letters, reports and other information related to my work history and records, without giving me prior notice of such disclosure. In addition, I hereby release COASL, my former employers and all other persons, corporations, partnerships and associations from any and all claims, demands or liabilities arising out of or in any way related to such investigation or disclosure.

I understand that any misrepresentations, omissions of facts or incomplete information requested in this application may remove me from further consideration for employment. In addition, if employed, any misrepresentations or omissions of facts called for in this application will be cause for dismissal without notice, regardless of the time elapsed before the discovery.

I understand that my employment with COASL is for no specific term and may be terminated by either COASL or myself, with or without notice or cause, at any time. I further understand that no oral promise, COASL policy, custom business practice or other procedure (including any personnel or other manuals) constitutes and employment contract or modification of the at-will employment relationship between COASL and myself.

I understand that the contents of any employee handbook or personnel manual, as well as other COASL policies and practices are subject to change or modification by COASL, solely at its discretion, without notice. I also understand that no supervisor or other COASL employee (except the President / CEO, in writing) has the authority to enter into any agreement with me or to make any agreement contrary to the foregoing.

______________________________________ ______________________

APPLICANT SIGNATURE DATE

COASL USE ONLY

Voluntary Invitation to Employees to Self-Identify

The Company is an Equal Opportunity/Affirmative Action employer, and as a federal contractor, we are required to take affirmative action to employ and advance females, minorities, and protected veterans. To comply with these laws, we invite you to voluntarily self-identify your race/ethnicity, gender, and protected veterans status. Please complete the information below and return as instructed. Submission of this information is voluntary and will not, in anyway, subject you to any adverse treatment. Responses will be kept confidential and will not be used in a manner that is inconsistent with any law.

GENDER

- Male
- Female
- I choose not to disclose

ETHNICITY

- **Hispanic or Latino**- All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.
- **Not Hispanic or Latino**- Everyone who is not "Hispanic or Latino" as defined above.
- I choose not to disclose

RACE

If you selected "Hispanic or Latino" DO NOT complete this section. Otherwise please check one:

- **White**- All persons having origins in any of the original people of Europe, North Africa, or the Middle East.
- **Black or African American**- All persons having origins in any of the black racial groups of Africa.
- **Native Hawaiian or Other Pacific Islander**- Any persons having origins in any of the people of Hawaii, Guam, Samoa or other Pacific Islands.
- **Asian**- All persons having origins in any of the original people of the Far East or the Indian Subcontinent. Ex China, Cambodia, Japan, Pakistan, the Philippine Island and Vietnam.
- **American Indian-** All persons having origins in any of the original people of North or South America, and who maintain cultural identification through tribal affiliation.
- **Two or more races**-All persons who identify with more than one of the above races.
- I Choose not to disclose

VETERAN STATUS

- Disabled Veteran
- Active Duty Wartime or Campaign Badge Veteran
- Armed Forces Service Medal Veteran
- Recently Separated Veteran Date of Discharge: _____________
- I Am Not a Protected Veteran
- I Choose Not to Disclose My Protected Veteran Status

Print Name: ___________________________ Date:______________________

Voluntary Self-Identification of Disability

Form CC-305

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: ________________