

NORTHEAST FAMILY CENTER

APPLICATION FOR EMPLOYMENT
AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

FOR OFFICE USE ONLY

INTERVIEW DATE _____

DATE	
NAME	
MAIDEN NAME	
SOCIAL SECURITY #	
PRESENT ADDRESS	
PERMANENT ADDRESS	
CITY, STATE, <u>ZIP</u>	
PHONE	
CELL PHONE	
WORK PHONE	
E-MAIL	
POSITION DESIRED	
WAGE DESIRED	
DATE AVAILABLE	
YES NO	DO YOU WISH TO BE CONSIDERED FOR OTHER POSITIONS?
YES NO	ARE YOU A U.S. CITIZEN?
YES NO	ARE YOU A VETERAN?
YES NO	ARE YOU CURRENTLY EMPLOYED?
YES NO	MAY WE CONTACT YOUR CURRENT EMPLOYER?
YES NO	ARE YOU UNDER 18?
YES NO	DO YOU HAVE CPR CERTIFICATION?

EMPLOYMENT HISTORY

EMPLOYER	
SUPERVISOR	
ADDRESS	
PHONE	
JOB DESCRIPTION	
DATES EMPLOYED	
REASON FOR LEAVING	

EMPLOYER	
SUPERVISOR	
ADDRESS	
PHONE	
JOB DESCRIPTION	
DATES EMPLOYED	
REASON FOR LEAVING	

EMPLOYER	
SUPERVISOR	
ADDRESS	
PHONE	
JOB DESCRIPTION	
DATES EMPLOYED	
REASON FOR LEAVING	

EDUCATION

NAME OF INSTITUTION	DEGREE COMPLETED

SPECIAL TRAINING OR CERTIFICATES

NAME OF INSTITUTION	SUBJECTS

VOLUNTEER WORK

NAME OF INSTITUTION	DESCRIPTION OF DUTIES

MULTI-CULTURAL EXPERIENCE

YES NO	HAVE YOU WORKED WITH ETHNIC AND RACE RELATIONS?
YES NO	HAVE YOU WORKED WITH PEOPLE WITH DISABILITIES?
OTHER	

PERSONAL REFERENCES

NAME	
ADDRESS	
DAY/CELL PHONE	
WORK PHONE	
EVENING PHONE	
RELATIONSHIP	
YEARS KNOWN	
PROFESSION	

NAME	
ADDRESS	
DAY/CELL PHONE	
WORK PHONE	
EVENING PHONE	
RELATIONSHIP	
YEARS KNOWN	
PROFESSION	

NAME	
ADDRESS	
DAY/CELL PHONE	
WORK PHONE	
EVENING PHONE	
RELATIONSHIP	
YEARS KNOWN	
PROFESSION	

NAME	
ADDRESS	
DAY/CELL PHONE	
WORK PHONE	
EVENING PHONE	
RELATIONSHIP	
YEARS KNOWN	
PROFESSION	

AFFIRMATIVE ACTION INFORMATION

Furnishing information about sex, age group, racial/ethnic group or disability is voluntary. Completion of this survey is not a requirement for consideration for employment and volunteer positions with The Northeast Family Center. This information will be used solely in connection with the Affirmative Action Plan. Our efforts are to determine the effectiveness of our recruitment and selection processes and to send specific information about job opportunities. The information you supply will be kept confidential. We would appreciate your cooperation by completing this form.

Instructions: Please circle only one number for each question below.

A. What gender are you?

1. Male
2. Female

B. Do you have a disability?

1. No
2. Yes – (Please State)

C. What is your age?

1. 16 years or less
2. 17-39 years
3. 40 years or more

D. Of the following, of which racial/ethnic group do you consider yourself a member?

1. **American Indian or Alaskan Native:** All persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or Community recognition.
2. **Asian or Pacific Islander:** All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. For example, China, Japan, Korea, Philippine Islands, and Samoa.
3. **White:** All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East. (Not of Hispanic origin.)
4. **Black:** All persons having origins in any of the Black racial groups of Africa. (Not of Hispanic origin.)
5. **Hispanic:** All persons of Mexican, Puerto Rican, Cuban, Central, or South American, or other Spanish culture or origin, regardless of race.
6. **Other:** Any origin not described in the categories above, or multi-racial.

NAME		
SIGNATURE	DATE	



Division of Public Health

Licensure Unit - Children's Services Licensing
 PO Box 94986 - Lincoln, NE 68509-4986
 Fax: 402-471-7763

**AUTHORIZATION FOR RELEASE OF INFORMATION FORM
 for Child Care Centers and Preschools**

Child Care Center and Preschool personnel (applicant, licensee, director, regularly identified substitute, and staff including teachers, assistant teachers and all support staff) listed on a license application for initial, renewal, and/or amendment licensure shall be screened against the Child Abuse/Neglect Register and the Nebraska Adult Protective Services Central Registry by the Department BEFORE issuing a license. *New candidates being considered for employment in a Child Care Center and/or Preschool must be screened against the same Register/Registry BEFORE being hired.*

Employee applicant: Date of Interview _____ Volunteer applicant: Planned Start Date _____

Facility Name: _____	
Address (site/mail): _____	Area Code/Phone#: _____
City/State/Zip: _____	Fax Number: _____

The Department needs your permission to check the Nebraska Child Abuse/Neglect Register and the Nebraska Adult Protective Services Central Registry to confirm that your name does not appear.

I authorize Nebraska Department of Health and Human Services to release information from the Child Abuse/Neglect Register **AND** the Nebraska Adult Protective Services Central Registry pertaining to me to the above named facility. The Department may state if my name appears or does not appear on the registers and may use information obtained for licensing determinations.

The submission of Social Security Numbers is voluntary; however, they are requested for the purpose of expediting the process of conducting the required background checks. Social Security Numbers will not be released without the individual's consent except as required by law. This authorization is valid as long as the person is a director, teacher, assistant teacher, support staff, household member, substitute, volunteer and/or helper for the child care facility and address named above, unless this authorization is revoked in writing.

Note: All persons under the age of nineteen years of age are minors; therefore, Releases completed by those individuals between the ages of 13 to 19 years of age must also be signed by the Parent and/or Guardian of said minor. *(In case any person under the age of nineteen years of age is married, he/she is no longer a "minor" and the signature of the parent and/or guardian is not required.)*

▲ Applicant Current Name (First, Middle, Last, Suffix (Jr/Sr/II/III)) _____	▲ Social Security Number _____
▲ Other Names (Marriages/Maiden/Alias/Nicknames. If none write NONE) _____	▲ Date of Birth _____
▲ Applicant Signature and Date of signature _____	▲ Parent/Guardian signature and Date (when applicable) _____

▼ ADDRESS HISTORY: Provide 20 years of history. Begin with current address, include Street, City, State, and Date moved to and away from each address (mm/yy - mm/yy).

DATES	STREET ADDRESSES	CITY & STATE

▼ CHILDREN: Full Names and Date of Birth of own children. If you have no children, write NONE.

FULL NAME	DATE OF BIRTH

DHHS/CSL Office Use Only

This form is may be completed online, printed and mailed to this office

FELONY/MISDEMEANOR STATEMENT
Nebraska Department of Health and Human Services
Regulation and Licensure (Child Care Licensing Program)



This form is to be completed by all providers, household members, substitutes, volunteers, licensees, directors, teachers, assistant teachers and all support staff, age 19 and older, at initial licensing AND whenever there have been changes in staff or household composition AND whenever an application is submitted.

This statement MUST include all law enforcement contacts regardless of prosecution. List details, dates and county of disposition (i.e., parole, probation, incarceration, fine, community service, etc.) from the age of 19 to the date this document is signed. Law enforcement records may be obtained and reviewed to determine the accuracy of this statement.

For each statement, if you have had NO law enforcement contacts, write "NONE"

My record of felony and/or misdemeanor **arrests** related to **crimes against children** include: _____

My record of misdemeanor **tickets**, other than minor traffic violations include: _____

My record of felony and/or misdemeanor **convictions** include: _____

Pending criminal charge(s) include: _____

My current parole or probation status is: _____

Law enforcement contacts regardless of prosecution include: _____

Signature Date of Birth Relationship to Facility

Print Full Name Other Names Used (previous married, maiden, alias, nicknames)

Name of Provider/Facility Telephone Number Date

Failure to provide accurate and complete information may result in disciplinary action against the applicant or licensee.
FOR FCCHI ONLY - Distribution: WHITE - Central Office; CANARY - Child Care Licensing; PINK - Provider/Applicant

