



Employment Application (March 2010)

The Autism Project

1516 Atwood Avenue
Johnston, RI 02919
401-785-2666

Applicant Information

Full Name: _____ Date: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____ *City State ZIP Code*

Phone: () _____ E-mail Address: _____

Date Available: _____ Social Security No.: _____ Desired Salary: \$ _____

Position Applied for: _____

Are you a citizen of the United States? YES NO
YES NO If no, are you authorized to work in the U.S.? YES NO

Have you ever worked for this company? If so, when? _____

Have you ever been convicted of a felony, including sex-related or child abuse related offenses? YES NO
If yes, explain: _____

If applying to work for children's programming, please check whether you are 19 or older younger than 19

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES NO Degree: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES NO Degree: _____

Other: _____ Address: _____

From: _____ To: _____ Did you graduate? YES NO Degree: _____

References

Please list three professional references.

Full Name: _____ Relationship: _____

Company: _____ Phone: () _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: () _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: (____) _____

Address: _____

Previous Employment

Company: _____ Phone: (____) _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES NO

Company: _____ Phone: (____) _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES NO

Company: _____ Phone: (____) _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES NO

Military Service

Branch: _____ From: _____ To: _____

Rank at Discharge: _____ Type of Discharge: _____

If other than honorable, explain: _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____



STAFF EMERGENCY INFORMATION

Name:		Date:
Address:		Home Phone:
Email:		Cell Phone:
Position:		
Has there been any change in your employment information during the past year (i.e., citizenship, criminal record, child protective services finding)? <input type="checkbox"/> No <input type="checkbox"/> Yes		
If yes, explain:		
Please complete the following information in the event that an emergency arises and we must contact someone immediately. Include information about how to reach the designated person.		
Name	Relationship	Phone #
Emergency Medical Information		
Name of Physician:		Phone:
Name of Practice:		Address:
Please check all items that apply to your present health. Thoroughly explain any checked answers on the back of this page.		
Allergies <input type="checkbox"/> No known allergies		
<input type="checkbox"/> Food:	<input type="checkbox"/> Plants:	
<input type="checkbox"/> Insects:	<input type="checkbox"/> Medicine Allergies:	
Other medical conditions that may be significant to work or to emergency care:		
Treatment for any of the above:		
<i>In case of emergency, I understand that every effort will be made to contact the emergency contact people listed above. In the event that someone cannot be reached, I understand that the Autism Project will use a standard 911 protocol.</i>		
Signature:		Date:
Printed name:		



CONFIDENTIALITY AGREEMENT

The Autism Project is a non-profit organization dedicated to empowering professionals and parent to educate and support individuals with autism. Our mission is to develop a comprehensive coordinated system of services and resources that meets the needs of people with an Autism Spectrum Disorder (ASD) and their families. The Autism Project requires that all staff, consultants, and volunteers maintain the confidentiality of information collected, stored, or shared as part of its operations. Confidential information includes any information that may be used to identify an individual child, program, school, or organization and that is not a matter of public record.

All information regarding individuals, their diagnoses, and other medical information, academic records, assessments, and program placement is confidential. This information will only be shared with staff, consultants, and volunteers on a "need to know" basis. Furthermore, any documents containing such information will be handled prudently. Such documents will bear the stamp "CONFIDENTIAL," be retained for as brief a timeframe as necessary, and then shredded through a professional service.

The Autism Project requires all staff, consultants, and volunteers to submit a signed Agreement as part of its Confidentiality Policy. Please sign this form for our records. Thank you for your cooperation and for your efforts to safeguard any and all confidential information you may come in contact with in your work with The Autism Project.

I have reviewed the above Confidentiality Policy and agree to maintain the confidentiality of information as required.

Printed Name:	
Signature:	Date:
Program:	



CRIMINAL BACKGROUND INVESTIGATION AUTHORIZATION

I, _____, of

_____,
(name)

(street address)

_____, do hereby authorize the Attorney General's Office of the State of Rhode Island to release to The Autism Project, any and all records relating to my criminal background, and I hereby release The Autism Project and all director, officers, and other individuals connected therewith from any and all liability for any damages related thereto. I have attached hereto a copy of my driver's license.

My date of birth is: _____

My driver's license number is: _____

State: _____

(signature of applicant)

(date)

NOTARY:

State of Rhode Island

County of _____

Subscribed and sworn to before me on this _____ day of _____,
20____.

(Notary Public Signature)



FINGERPRINTING

To Whom It May Concern:

This letter verifies the _____,
SS# _____ is an employee of The Autism Project.

The Autism Project requires that all employees working with children in educational environments be fingerprinted for a nationwide criminal background check in accordance with the RI General Laws 40-13.2-5 (Childcare), as well as have a Rhode Island BCI conducted as required by the Rhode Island Department of Children, Youth, and Families.

If you have any questions, please contact our Administrative Assistant, Jill Norwood, at (401) 785-2666, ext. 1011.

Sincerely,

Joanne Quinn
Executive Director

Note: Fingerprinting should be done *by appointment* at the police department in your city/town of residence, or at the RI State Police Headquarters in N.Scituate (401-444-1110). The Fingerprint Affidavit must be returned to The Autism Project prior to employment.

