



TRI-COUNTY YMCA OF THE OZARKS

Prospective employees will receive consideration without discrimination because of race, color, sex, age, national origin, handicap, or veteran status.

Last Name	First	Middle	Date
Street Address			Home Telephone ()
City	State	Zip	Business Telephone ()
Have you ever applied for employment with us? YES NO If yes; Month & Year			Social Security#
Position Desired			Are you of legal age to work? YES NO
Are you legally eligible for employment in the Unites States? YES NO			Will you work overtime if asked? YES NO
Apart from absence for religious observances, are you available for full-time work? YES NO If not, what hours can you work?			When will you be available to begin work?
Other special training or skills (language, machine operation, etc.)			

School	Name and Location of School	Course of Study	No. of years completed	Did you graduate? If so, what year?	Degree or Diploma?
Elementary					YES NO
High School					YES NO
Business/Trade/Technical					YES NO
College					YES NO
Graduate					YES NO

Membership in Professional or Civic Organizations

(Exclude those which may disclose your race, color, religion, or national origin)

Please give accurate, complete full-time and part-time employment records.
 Start with your present or most recent employer.

Company Name	Telephone
Address	Employed (State month and year) From _____ To _____
Name of Supervisor	Weekly Pay Start _____ Last _____
State job title and describe your work	Reason for leaving

Company Name	Telephone
Address	Employed (State month and year) From _____ To _____
Name of Supervisor	Weekly Pay Start _____ Last _____
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Company Name	Telephone
Address	Employed (State month and year) From _____ To _____
Name of Supervisor	Weekly Pay Start _____ Last _____
State job title and describe your work	Reason for leaving

We may contact the employers listed above unless you indicate those you do not want us to contact.	<u>DO NOT CONTACT</u>
	<u>Employer</u>
	<u>Reason</u>

Are you, or have you ever been employed by the YMCA? YES NO If yes, when? _____ What location? _____ Name under which employed? _____	Are you a Vietnam Veteran? YES NO
Have you ever participated in the YMCA Retirement fund? YES NO If yes, when? _____	Sex: Male Female
Were you referred to the YMCA by: Own Accord _____ YMCA Employee _____ Other _____	How long at present address? _____ years
Have you ever been bonded? YES NO If yes, with what employers? _____	How long at previous address? _____ years
Have you been convicted of a crime in the past ten years. YES NO If yes, describe in full:	Are you over 18 years of age? YES NO If no, employment is subject to verification of age.
State names of relatives and friends working for us, other than your spouse:	<u>Military</u> Did you serve in the U.S. Armed forces? YES NO If yes, what branch? _____
Describe any training received relevant to the position for which you are applying:	

I certify that facts set forth in this application for employment are true and complete to the best of my knowledge. I understand if employed, false statements on this application shall be considered sufficient cause for dismissal. It is understood employment with the Tri-County YMCA of the Ozarks is subject to passing a criminal records check; therefore, I authorize the Company to conduct a police record check and make any investigation of my prior educational and work history.

I understand if I am hired, the length of my employment is not guaranteed. Recognizing I will be free to voluntarily terminate my employment at any time with or without cause, I acknowledge the Company will be free to terminate my employment at any time, with or without cause.

Signature

Date

FOR EMPLOYERS USE ONLY

Employer	Person Contacted	Results
1.		
2.		
3.		
4.		

Tests Administered	Raw Score	Rating	Analysis & Comments

Interview and Comments



YMCA Mission: To put Christian principals into practice through programs that build healthy body, mind, and spirit for all.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 FAMILY CARE SAFETY REGISTRY
WORKER REGISTRATION

FCSR USE ONLY

PLEASE TYPE OR PRINT CLEARLY

SECTION A: WORKER TYPE (CHECK ALL (✓) BOXES THAT APPLY)

- | | |
|---|--|
| <input type="checkbox"/> CHILD CARE WORKER | <input type="checkbox"/> FOSTER PARENT |
| <input type="checkbox"/> ELDER CARE WORKER | <input type="checkbox"/> VOLUNTARY REGISTRANT |
| <input type="checkbox"/> PERSONAL CARE WORKER | <input type="checkbox"/> RECIPIENT OF STATE OR FEDERAL FUNDS |

SECTION B: IDENTIFYING DATA FOR BACKGROUND SCREENING

LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME
PRIOR NAMES USED			

SOCIAL SECURITY NUMBER (ATTACH COPY OF SOCIAL SECURITY CARD)	DATE OF BIRTH	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	TELEPHONE NO. (optional) ()
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MAILING ADDRESS

STREET ADDRESS OR POST OFFICE BOX	CITY	STATE	ZIP CODE	COUNTY
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HOME ADDRESS (if different than mailing address)

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY
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SECTION C: CURRENT EMPLOYER INFORMATION (IF APPLICABLE)

EMPLOYER NAME	CONTACT PERSON	PHONE NUMBER ()
ADDRESS	CITY	STATE ZIP CODE COUNTY

SECTION D: AUTHORIZATION TO RELEASE BACKGROUND SCREENING INFORMATION

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the Missouri Department of Health and Senior Services to release the fact that I am a registrant in the Family Care Safety Registry and any related background information to the requestor of the Family Care Safety Registry for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the Family Care Safety Registry, "employment purposes" includes direct employer-employee relationships, prospective employer-employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child-care, elder-care or personal care setting. I understand that if I dispute the information contained in the Family Care Safety Registry I have the right to appeal the accuracy in the transfer of information to the Registry within thirty (30) days of receiving the results of the background screening determination.

SIGNATURE OF APPLICANT (REQUIRED IN INK)	DATE
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IMPORTANT

- Individuals are required to register one-time only
- Contact 1-866-422-6872 (toll-free) if you have questions on how to complete this form
- Read back of form for instructions and information on registrant notification and appeal rights
- Send completed registration form, copy of social security card and \$5.00 check or money order made payable to:

Missouri Department of Health and Senior Services
 Fee Receipts Unit
 P.O. Box 570
 Jefferson City, MO 65102

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