APPLICATION FOR

☐ EMPLOYMENT ☐ INTERNSHIP ☐ VOLUNTEER

PERSONAL

Last Name First Middle	Date
Street Address	Home Phone
City, State, Zip	Business Phone
Have you ever applied for employment with us? ☐ Yes ☐ No If yes, indicate month/year and location:	Social Security Number
Position Desired	Pay Expected
Apart from absence for religious observance, are you available for full-time work? ☐ Yes ☐ No If not, what hours can you work?	Will you work overtime, if asked? ☐ Yes ☐ No
Can you travel if a job requires it? ☐ Yes ☐ No	When will you be available to begin work?

Are you legally eligible for employment in the United States of America? ☐ Yes ☐ No

Are you a citizen of the United States of America? ☐ Yes ☐ No

If not, do you possess an Alien Registration Card? ☐ Yes ☐ No
If yes, what is your Alien Registration Number?

Do any of your friends or relatives, other than your spouse, work here? ☐ Yes ☐ No
If yes, list name(s):

Other special training or skill (languages, machine operation, etc.)

How did you learn of MCCA?

EDUCATION

SCHOOL	NAME AND LOCATION OF SCHOOL	COURSE OF STUDY/MAJOR	DATES OF ATTENDANCE	DID YOU GRADUATE	DEGREE OR DIPLOMA
College				☐ Yes ☐ No	
High				☐ Yes ☐ No	
Elementary				☐ Yes ☐ No	
Other				☐ Yes ☐ No	

MILITARY

COMPLETE THIS SECTION IF YOU SERVED IN THE U.S. ARMED FORCES	Branch of service:
Describe your duties and any special training:	Period of active duty (month/year) From To
	Rank at discharge

DO NOT ANSWER ANY QUESTION IN THIS SECTION UNLESS THE BOX IS CHECKED

If the employer has checked the box next to the question, the information requested is needed for a legally permissible reason, including, without limitation, national security considerations, a legitimate occupational qualification or business necessity. The Civil Rights Act of 1964 prohibits discrimination in employment because of race, color, religion, sex or national origin. Federal law also prohibits discrimination on the basis of age with respect to certain individuals. The laws of most states also prohibit some or all of the above types of discrimination as well as some additional types such as discrimination based upon ancestry, marital status or physical or mental handicap or disability.

☐	Marital status: ☐Single ☐Engaged ☐Married ☐Separated ☐Divorced ☐Widowed	Height: Weight: Sex: ☐ Male ☐Female
☐	What was your previous address:	How long at present address: years How long at previous address: years
☐	Have you ever been bonded? ☐ Yes ☐ No If yes, with what employer(s)?	
☐	Have you received Workmen's Compensation or Disability Income payments? ☐ Yes ☐ No If yes, describe.	
☐	Do you have physical defects which preclude you from performing certain jobs? ☐ Yes ☐ No If yes, describe.	

Please provide accurate, complete full-time and part-time employment record. Start with present or most recent employer.

EMPLOYMENT	
Company Name:	Telephone:
Address:	Employed (month/year): From To
Name of Supervisor	End
Job Title and Description	Reason for Leaving

EMPLOYMENT	
Company Name:	Telephone:
Address:	Employed (month/year): From To
Name of Supervisor	End
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EMPLOYMENT	
Company Name:	Telephone:
Address:	Employed (month/year): From To
Name of Supervisor	End
Job Title and Description	Reason for Leaving

We may contact the employers listed above unless you indicate those you do not want us to contact:

DO NOT CONTACT.. *EMPLOYER*____

*REASON*____

AGREEMENT

I, ____, *(print name legibly)* understand that the employer follows an "employment at will" policy, in that I or the employer may terminate my employment at any time or for any reason consistent with applicable state or federal law. I understand that this application is not a contract of employment. I understand that to be employed, I must be lawfully authorized to work in the United States of America, and I must show the employer documents that will prove this.

I understand that MCCA will investigate my work and personal history and verify all data given on this application, on related papers and in interviews. I authorize all individuals , schools and firms named therein, except my current employer if so noted, to provide any information requested about me, and I release them from all liability for damage in providing this information.

I certify that all the statements herein are true and understand that any falsification or willful omission shall be sufficient cause for dismissal or refusal of employment.

*YOUR SIGNATURE:*____

We are an equal opportunity employer.

MISSION STATEMENT

To provide HELP and instill HOPE
for individuals, families and organizations
working to overcome and prevent addictions.

PLEASE READ CAREFULLY
APPLICANT AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

In consideration for employment or promotion within MCCA, on our behalf, Employers Reference Source will make inquiries, including but not necessarily limited to, your education, professional licensing, criminal history, driving history pertinent to your qualifications for employment, including reasons for termination from your past employment. In compliance with the Americans With Disabilities Act, only after a contingent offer of employment is offered, may your workers' compensation history be investigated for the purpose of making certain that you are not hired for a position or assigned to a job function that could aggravate a previous injury.

Please complete and sign the form which follows, authorizing, without reservation, any party, including but not limited to, employers, law enforcement agencies, state agencies, institutions and private information bureaus or repositories, contacted by Employers Reference Source to furnish any or all of the above listed information. Your authorization releases Employers Reference Source from any and all liability for damages arising from the investigation and disclosure of the requested information. Further, it releases and discharges all liability from all companies, agencies, officials, officers, employees and other persons, who, in good faith, provide to Employers Reference Source the above mentioned information as requested, in order to successfully complete a background investigation.

Your signature allows a photocopy or fax copy of this authorization to be as valid as the original.

Print Full Name:____

Yes No

Have you used any other name? Y N

If yes, what name(s) did you use? ____________________________________

Social Security #: ______________________ Date of Birth*:______________________

Driver's License #: ______________________ State Issued:______________________

College: ____

Name Used: ____

Month and Year of Graduation: ______________________________________

Degree Awarded:____________________ Course of Study: ______________________

Applicant Signature: ______________________________ Date: __________________

* Date of birth is being requested only for purposes of identification in obtaining accurate retrieval of records. It will not be used for discriminatory purposes.

Department of Children and Families
AUTHORIZATION FOR RELEASE OF INFORMATION FOR DCF CPS SEARCH
DCF-3031
12/15 (Rev.)

I, ______________________________ do hereby authorize the Department of Children and Families to research
Applicant Name
its records to determine whether or not I am on the central registry of persons responsible for child abuse and neglect I understand that this information may be used to determine my suitability solely for *(check one):*

☐ Employment ☐ Day Care ☐ Volunteer ☐ Intern ☐ Mentor ☐ Other:

Name of Agency:			Attention:	
Address: (No. and Street):	Apartment #	City:	State:	Zip:

I release the Department of Children and Families from any liability for any damages I may incur which may result from the release / use of this information. I submit my following information to assist the Department. of Children and Families in their search.

Last Name	First Name:	Middle:	DOB:		SS:
Address: (No. and Street):	Apartment #:	City:	State:	Zip:	Years at current address?: Years Months

Previous Address(es)/List All for the Last Five Years *(continue on reverse side of form if necessary)* ☐ Check if reverse side used

Address: (No. and Street):	Apartment #:	City:	State:	Zip:	Dates From: (Month/Year)		Dates To: (Month/Year)	

Other Names I have Used – *Including Maiden, Previous Marriages(s) (continue on reverse side of form if necessary* ☐ Check if reverse side used

Last Name	First Name:	Middle:	DOB:	SS:

Name of Spouses/Other Adults in the Home – *Past and Present (continue on reverse side of form if necessary* ☐ Check if reverse side used

Last Name	First Name:	Middle:	DOB:	Signature (if still in Home)	Date:

Names of ALL Child(ren) – *Biological, Stepchildren Including Adult Children In or Out of the Home* ☐ Check if reverse side used

Last Name	First Name:	Middle:	DOB:	Gender:

Do you have an active DCF investigation at this time? ☐ Yes ☐ No Do you have an active appeal of a DCF investigation at this time? ☐ Yes ☐ No

Applicant Signature:	Date:

THIS AUTHORIZATION WILL EXPIRE 180 DAYS AFTER THE DATE OF THE SIGNATURE. FORMS NOT FILLED OUT COMPLETELY AND / OR CLEARLY WILL BE RETURNED. DO NOT LEAVE ANY BLANK SPACES. PLEASE SPECIFY WITH N/A IF NOT APPLICABLE.

****DCF Conducts a Search of the CT Registry ONLY*** The Accuracy of this Search is Limited to the Information Provided by the Applicant to DCF

Mail to: DCF Careline Background Searches – 505 Hudson Street – 5th Floor – Hartford, CT 06106 or FAX: 860-560-7071

DCF-CT Careline CPS-BGC USE ONLY - DO NOT WRITE BELOW THIS LINE

Date:	Central Registry?: ☐ Yes ☐ No	Processors Initials: