

THE QUAD MANHATTAN

Employment Application



APPLICANT INFORMATION			
Last Name	First	M.I.	Date
Street Address		Apartment/Unit #	
City	State	ZIP	
Phone	E-mail Address		
Date Available	Social Security No.	Desired Salary	
Position Applied for			
Are you a citizen of the United States?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If no, are you authorized to work in the U.S.? YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you ever worked for this company?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so, when?
Have you ever been convicted of a felony?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, explain

EDUCATION			
High School		Address	
From	To	Did you graduate? YES <input type="checkbox"/> NO <input type="checkbox"/>	Degree
College		Address	
From	To	Did you graduate? YES <input type="checkbox"/> NO <input type="checkbox"/>	Degree
Other		Address	
From	To	Did you graduate? YES <input type="checkbox"/> NO <input type="checkbox"/>	Degree

REFERENCES	
<i>Please list three professional references.</i>	
Full Name	Relationship
Company	Phone ()
Address	
Full Name	Relationship
Company	Phone ()
Address	
Full Name	Relationship

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 <input type="checkbox"/> NO <input type="checkbox"/>			
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 <input type="checkbox"/> NO <input type="checkbox"/>			
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 <input type="checkbox"/> NO <input type="checkbox"/>			

MILITARY SERVICE	
Branch	From To
Rank at Discharge	Type of Discharge
If other than honorable, explain	

RESUME AND COVER LETTER ATTACHMENT	
A most recent resume and cover letter must be attached to this application with a statement of intentions for working with The Quad Manhattan and teaching philosophy if applicable.	
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
Witness Signature	Date



HOUSEHOLD MEMBERS ~DO NOT USE THIS FORM~

Medical Statement

(CHECK ONE) Provider Substitute Volunteer
 Director Assistant Teacher Other Staff

INSTRUCTIONS



Submit



Maintain On-Site

- A signature is required on both pages of this form.
- Only a health care provider (physician, physician's assistant, nurse practitioner) may complete and sign the Medical Condition section
- **A registered nurse is NOT authorized to sign the Medical Condition section**
- A health care provider may use an equivalent form as long as the information on this form is included

Applicant Name:

Date of Birth:

Typical Duties of Day Care Program

- | | |
|----------------------------------|--|
| ▪ Lifting and carrying children | ▪ Driver of vehicle |
| ▪ Close contact with children | ▪ Food preparation |
| ▪ Direct supervision of children | ▪ Facility maintenance |
| ▪ Desk work | ▪ Evacuation of children in an emergency |

Medical Condition

Date of Exam: ____ / ____ / ____

On the basis of my findings and on my knowledge of the above-named individual, I find that:

- He/she is physically fit to provide child day care and perform the duties listed above. **YES** (symptom free) **NO** (NOT symptom free)
- He/she is currently not exhibiting signs or symptoms of a communicable disease that could be transmitted during day care. **YES** (symptom free) **NO** (NOT symptom free)
- He/she is currently not exhibiting signs or symptoms suggestive of an emotional or psychological disorder that would hinder his/her ability to care for children. **YES** (symptom free) **NO** (NOT symptom free)

For any "No" responses, indicate _____

Restrictions:

Signature (physician, physician's assistant, nurse practitioner)

Name (Please PRINT clearly)

Title

() -

/ /

Phone

Date



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Medical Statement

(CHECK ONE) Provider Substitute Volunteer
 Director Assistant Teacher Other Staff

INSTRUCTIONS



Submit



**Maintain
On File**

- A health care provider (physician, physician's assistant, nurse practitioner) or a registered nurse (as part of their duties at a health care facility) may enter the Mantoux results in the TB section and sign this page

Applicant Name: _____

Date of Birth: _____

 Following to be completed by Health Professional ONLY

Tuberculin Test Information

Test Read on: _____ Not Tested Reason: _____
(mm / dd / yyyy)

 State Medical Exemption

If applicant was previously Positive, indicate date:

(mm / dd / yyyy)

Mantoux Result: Positive Negative _____ mm

If positive, does this person's contact with children enrolled in child care pose a risk to the children's health and safety? Yes No

Signature <i>(physician, physician's assistant, nurse practitioner OR a registered nurse)</i>	
Name <i>(Please PRINT clearly)</i>	Title
() -	/ /
Phone	Date