# Pre-Hire Packet

☐ Employment Application

☐ Pre-Employment Statement

☐ Authorization to Release Medical Information

☐ Background Investigation Authorization

☐ Veteran Pre-Offer

☐ Voluntary Self ID of Disability

☐ Voluntary EOE Self ID

Please complete and email packet to Donna.Mcneil@sheppardpratt.org
If you have any questions, please call 443-462-2627.

Alliance

# Employment Application

We are an Equal Opportunity Employer. Applicants are considered for positions and are evaluated without regard to mental or physical disability, race, religion, sexual orientation, color, gender, national origin, age, marital status, military or veteran status, or any other protected local, state, or federal status unrelated to the performance of the work involved.

Please answer all questions completely. Please do not provide any information not specifically requested on this Employment Application form.

| **First Name:** | **Last Name:** | **Middle Initial:** |
|---|---|---|

| **Address (Including Apt.#):** | **City:** | **State:** | **Zip Code:** |
|---|---|---|---|

| **Cell Phone #:** | **Work Phone #:** | **Other #:** |
|---|---|---|

**Email:**

**Desired Employment Type:** ☐ Full-Time ☐ Part-Time ☐ On Call

**Desired Shift:** ☐ Day ☐ Evening ☐ Night

| **Desired Position:** | **Desired Start Date:** | **Desired Salary/Hourly Wage:** |
|---|---|---|

**Are you eligible to work in the United States:** ☐ Yes ☐ No

**Are you 18 years old or older?** ☐ Yes ☐ No

**Have you previously been employed with Alliance?** ☐ Yes ☐ No
If yes; dates from: to:

**Do you have any relatives employed with Alliance?** ☐ Yes ☐ No
If yes; list names:

**How did you learn about this job?**

| City & State of School/Institution | Did you graduate? | Major / Area of Study | GPA | Degree |
|---|---|---|---|---|
| **High School:** | ☐ Yes ☐ No<br>☐ Currently enrolled | | | |
| **College/University:** | ☐ Yes ☐ No<br>☐ Currently enrolled | | | |
| **Graduate School:** | ☐ Yes ☐ No<br>☐ Currently enrolled | | | |

| **Business/Trade School:** | ☐ Yes ☐ No<br>☐ Currently enrolled | | | |
|---|---|---|---|---|

**Tell us your work experience, listing your prior employers beginning with your present or most recent employer.**

| **1. Employer Name:**<br>**Address:**<br>**City/State/Zip:**<br>**Phone Number:** | | | |
|---|---|---|---|
| **Employment Dates:**<br>**From: To:** | **Starting/Ending Salary:**<br>**$ $** | ☐ **Part Time**<br>☐ **Full Time** | **Your Job Title:** |
| **Supervisor's Name:**<br>**Supervisor's Title:** | | | **May we contact?**<br>☐ Yes ☐ No |
| **Describe Major Duties:** | | | **Reason for Leaving:** |

| **2. Employer Name:**<br>**Address:**<br>**City/State/Zip:**<br>**Phone Number:** | | | |
|---|---|---|---|
| **Employment Dates:**<br>**From: To:** | **Starting/Ending Salary:**<br>**$ $** | ☐ **Part Time**<br>☐ **Full Time** | **Your Job Title:** |
| **Supervisor's Name:**<br>**Supervisor's Title:** | | | **May we contact?**<br>☐ Yes ☐ No |
| **Describe Major Duties:** | | | **Reason for Leaving:** |

| **3. Employer Name:**<br>**Address:**<br>**City/State/Zip:**<br>**Phone Number:** | | | |
|---|---|---|---|
| **Employment Dates:**<br>**From: To:** | **Starting/Ending Salary:**<br>**$ $** | ☐ **Part Time**<br>☐ **Full Time** | **Your Job Title:** |
| **Supervisor's Name:**<br>**Supervisor's Title:** | | | **May we contact?**<br>☐ Yes ☐ No |
| **Describe Major Duties:** | | | **Reason for Leaving:** |

| **4. Employer Name:**<br>**Address:**<br>**City/State/Zip:**<br>**Phone Number:** | | | |
|---|---|---|---|
| **Employment Dates:**<br>**From: To:** | **Starting/Ending Salary:**<br>**$ $** | ☐ **Part Time**<br>☐ **Full Time** | **Your Job Title:** |
| **Supervisor's Name:**<br>**Supervisor's Title:** | | | **May we contact?**<br>☐ Yes ☐ No |

| **Describe Major Duties:** | **Reason for Leaving:** |
|---|---|
| | |

| **In your own words, please provide a brief descriptions telling why you are an ideal candidate.** |
|---|
| |

| Military Service Branch: | Start Date | End Date | Highest Rank Attained | Duties |
|---|---|---|---|---|
| | | | | |
| | | | | |

| Supervisory References | | | |
|---|---|---|---|
| **Name** | **Company** | **Relationship** | **Phone #** |
| | | | |
| | | | |
| | | | |

# Pre-Employment Statement

*Please read before signing*

I understand that the organization will rely, in part, on the information I provide in this Employment Application in considering whether to hire me. I understand that it is important that I provide complete and accurate information and certify that I have done so. If the organization discovers at any time that I failed to completely and honestly provide any information requested of me in this Employment Application or during the interview process, I understand that my application will no longer be considered or, if I am working for the organization, that I will be subject to disciplinary action, up to and including termination of employment.

The organization is committed to compliance with the provisions of this nation's immigration laws regarding verification of employment eligibility. Any offer of employment will be contingent upon your ability to provide legally sufficient documentation showing your eligibility to be employed by this organization. Applicants or employees that present fraudulent documents for employment verification purposes will be terminated.

I authorize the organization to contact anyone that it deems appropriate to verify the information I have provided or to further investigate my background, past performance and suitability for employment. I consent to being discussed by any person contacted by the organization and waive all rights to bring any action for defamation, invasion of privacy or any similar claim against anyone that provides information to the organization may choose to obtain background information about me from a consumer reporting agency. Before requesting a report from a consumer reporting agency, the organization will ask for my authorization. I understand that if I refuse to provide such authorization, my application for employment will not be considered.

I understand that this Employment Application is not an offer of employment. I understand that nothing contained in this Employment Application creates a contract between the organization and me for employment or any other benefit. No promises regarding employment have been made and I understand that no such promise or guarantee is binding upon the organization.

**I understand that I am hired, I will be an employee "at will," meaning, I am not hired for any definite length of time and either I or the organization can terminate my employment at any time for any or no reason.**

If employed, I understand and agree that the organization retains the sole right in its business judgement to modify, suspend, interpret, or cancel, in whole or in part, at any time, with or without any notice, any published or unpublished policy, practice, procedure, process, or benefit.

If employed, I understand that I may be required to comply with federal and/or state Drug Free Workplace Laws and regulations. I understand and agree to comply with such laws.

If employed, I understand that as a condition of employment that I may be required to agree to and sign the organization's confidentiality, non-complete, and/or other similar agreements. I also agree to notify the organization during the pre-employment process of any confidentiality, non-compete, and/or other similar agreement that I may have already signed with current and/or former employers.

**State Specific Notices- Maryland Applicants:** UNDER MARYLAND LAW, AN EMPLOYER MAY NOT REQUIRE OR DEMAND AS A CONDITION OF EMPLOYMENT, PERSPECTIVE EMPLOYMENT, OR CONTINUED EMPLOYMENT, THAT AN INDIVIDUAL SUBMIT TO OR TAKE A LIE DETECTOR OR SIMILAR TEST. AN EMPLOYER WHO VIOLATES THIS LAW IS GUILTY OF A MISDEMEANOR AND SUBJECT TO A FINE NOT EXCEEDING $100.

Applicant's Name: ___________________________________________________

Applicant's Signature: _______________________________________________ Date: ____________________

# Authorization to Release Medical Information

***Please do not highlight any part of the form***

In order to verify my medical information, I, ________________________________________________________, authorize Alliance, Inc. to obtain a description of my diagnosis and current symptoms from the licensed physician, psychiatrist or qualified psychologist listed below:

Name (doctor, therapist, etc.): ________________________________________________________

Organization: ____________________________________________________________________

Address: _______________________________________________________________________

_______________________________________________________________________

I understand this consent expires one year from the date of my signing and I may cancel my consent at any time except to the extent that action has been taken on it. To cancel my consent, I will put my request in writing to the manager of the program in which I am involved.

I have been informed of the information being released, the benefits and disadvantages (if any) I understand Alliance Inc. works through Federal and State set aside programs that require employing people with disabilities and my employment may be based on the verification of my disability. I understand my records are confidential under federal law and cannot be disclosed without my written consent, unless otherwise permitted in accordance with Federal law and regulations.

Name: ____________________________________________

Date of Birth: ______________________________________

Address: __________________________________________

__________________________________________

Individual's Signature: ________________________________ Date: ____________________

Witness/Staff Signature: _______________________________ Date: ____________________

**Due to regulations, the provider's answers to the questions below are required on the provider's letterhead or for the doctor's office to stamp the requested area on this form.**

**Stamp Doctor's Signature:**

## Medical Examination Report

**Stamp Signature Date: ___________________**

| **Patient Name:** | **DOB:** |
|---|---|
| **Address:** | **Phone #:** |
| | |
| **Agency Name:** | **Phone #:** |
| **Address:** | |
| ***Physician/Therapist Name:** | **Credentials:** |
| **Signature:** | **Date:** |

In order for a nonprofit agency to comply with ABILITYONE regulations, it **must verify** each individual's medical information to determine whether or not that individual **meets the program's disability requirements**.

## Physical Examination Report

*(*To be completed by a medical professional physician, psychiatrist, psychologist, or nurse practitioner)*

**Medical Conditions, Clinical Manifestations, and Diagnosis:**
(*Please state the nature and extent including applicable DSM V TR codes*)

**Describe Observations, Clinical Findings and Treatment Recommendations:**

| **Patient Name:** | **DOB:** |
|---|---|
| ***Physician/Therapist Name:** | **Credentials:** |

*Please Note: If the patient does not have any limitations, i.e. all boxes for "NONE" are checked in the functional limitations chart, they will not be eligible for hire under Alliance's disabled roster.*

| Functional Limitations | Degree of Limitations |
|---|---|
| Restrictions of Activities of Daily Living & Self Care | ☐ Mild ☐ Moderate ☐ Marked ☐ Severe ☐ None |
| Difficulties in Maintaining Social Functioning, Primarily with Communication | ☐ Mild ☐ Moderate ☐ Marked ☐ Severe ☐ None |
| Self-Direction: Difficulties in Maintaining Concentration, Persistence, and/or Pace | ☐ Mild ☐ Moderate ☐ Marked ☐ Severe ☐ None |
| Work Tolerance and Skills: Able to maintain job without intervention or support from the outside | ☐ Mild ☐ Moderate ☐ Marked ☐ Severe ☐ None |

Janitorial positions may require employees to:
stand, walk use hand(s) to feel, or handle; reach with hands and arms; and stoop, kneel, crouch or crawl

| Physical Capacities | Less Than 2 Hours | At Least 2 Hours | About 6 Hours |
|---|---|---|---|
| Sit | | | |
| Stand | | | |
| Walk | | | |

**Check the heaviest weight the patient can lift/carry:**
☐ Less than 10lbs ☐ 10lbs ☐ 20lbs ☐ 25lbs ☐ 50lbs ☐ 100lbs ☐ More than 100lbs

**Evaluation:**
Based upon your evaluation, can the patient's medical condition be expected to last, at least, 12 months?
☐ Yes ☐ No

Is the patient's medical condition expected to result in death? ☐ Yes ☐ No

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**Remarks:**
Please provide any additional information clarifying how the patient's condition limits their ability to work. If possible, include a description of any restrictions in Activities of Daily Living, Communication, Self- direction, or otherwise:

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

*Please attach records of other additional medical or mental health evidence.*

**Authorization of Background Investigation**

I have carefully read and understand this Disclosure and Authorization form and the attached summary of rights under the Fair Reporting Act. By my signature below, I consent to preparation of background reports by a consumer reporting agency, such as HireRight, Inc. (HireRight), and to the release of such background reports to the Company and its designated representatives and agents, for the purpose of assisting the Company in making a determination as to my eligibility for employment (including independent contractor assignments, as applicable), promotion, retention or for other lawful employment purposed. I understand that if the Company hires me or contracts for my services, my consent will apply, and the Company may, as allowed by law, obtain additional background reports pertaining to me, without asking for my authorization again, throughout my employment or contract period from HireRight and/or other consumer reporting agencies.

I understand that information contained in my employment or contract application, or otherwise disclosed by me before or during my employment or contract assignment, if any, may be used for the purpose of obtaining and evaluating or contract for service.

I hereby authorize all of the following, without limitation, to disclose information about me to the consumer reporting agency and its agents: law enforcement and all other federal, state and local agencies, learning institutions (including military, and all other individuals and sources with any information about or concerning me. The information that can be disclosed to the consumer reporting agency and its agents includes, but is not limited to, information concerning my employment and earnings history, education, credit history, motor vehicle history, criminal history, military service, professional credentials and licenses.

By my signature below, I also certify the information I provided on and in connection with this form is true, accurate and complete. I agree that this form in original, faxed, photocopied or electronic (including electronically signed) form; will be valid for any background reports that may be requested by or on behalf of the Company.

**Identifying Information for Consumer Reporting Agency**

Printed Name: ____________________________________________________________
(First, Middle, Last)

Other Names Used: (Alias, Maiden, Nickname) _____________________________________

# of Years Names Used: _________________ Date of Birth: _________________ Gender: ___________

Current Address: ___________________________________________________________
(Street, PO Box, City, State, Zip, County, Date Moved There)

Former Address: ___________________________________________________________
(Street, PO Box, City, State, Zip, County, Dates Lived There)

Social Security #: ______________________________ Phone #: ___________________________________

Driver's License or State ID #: ______________________________ State of Insurance: ______________

Signature: ___________________________________________________ Date: _________________________

# Pre-Offer Invitation to Self-Identify
# Protected Veterans

1. This employer is a government contractor subject to the Vietnam Era Veteran's Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA), which requires government contractors to take affirmative action to employ and advance in employment: (1) disabled veterans; (2) recently separated veterans; (3) active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans. These classifications are defined as follows:

   - A "disabled veteran" can be a veteran of the U.S. military, ground, naval, or air service who is entitled to compensation (or who, but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or a person who was discharged or released from active duty because of a service-connected disability.
   - A "recently separated veteran" means any veteran during the three year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.
   - An "active duty wartime or campaign badge veteran" means a veteran who served on active duty in the U.S. military, ground, naval, or, air service during a war, or in a campaign, or expedition for which a campaign badge has been authorized under the laws administrated by the Department of Defense.
   - An "Armed Forces service medal veteran" means a veteran who, while serving on active duty in the U.S. military, ground, naval, or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

Protected veterans may have additional rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA). In particular, if you were absent from employment in order to perform services in the uniformed service, you may be entitled to be reemployed by your employer in the position you would have obtained with a reasonable certainty, if not for the absence due to service. For more information, call the U.S. department of Labor's Veterans Employment and Training Service (VETS) at 866-4-USA-DOL.

2. If you believe you belong to any of the categories of protected veterans listed above, please indicate by checking the appropriate box below. As a government contractor, subject to VEVRAA, we request this information in order to measure the effectiveness of the outreach and positive recruitment efforts we undertake pursuant to VEVRAA.

   - ☐ I identify as one or more of the classifications of protected veterans listed above.
   - ☐ I am not a protected veteran

3. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information provided will be used only in ways that are not inconsistent with the Vietnam Era Veteran's Readjustment Assistance Act of 1974, as amended.

4. Then information you submit will be kept confidential, except that (1) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans, and regarding necessary accommodations; (2) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment; and (3) government officials engaged in enforcing laws administered by the Office of Federal Contract Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed.

5. This employer acts pursuant to affirmative action and equal employment opportunity policies and pledges to provided equal opportunity to all persons without regard to race, sex (including pregnancy), color, age, physical or mental disability, religion, national origin, sexual orientation, gender identity, veteran's status, or any other legally protected characteristic.

________________________________ ____________________

Name Date

**Voluntary Confidential Self-Identification**

Alliance, Inc. is subject to certain governmental record keeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, Alliance, Inc. invites candidates to voluntarily self-identify their race and ethnicity. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those which require the information be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual. This data will be kept in a confidential file, separate from the application for employment.

Name: ____________________________________________________ Date: __________________

*The following questions are optional and kept confidential.*
Please check one:

**Gender:** ❑ Male ❑ Female ❑ Other ❑ N/A

**Ethnicity:** (Are you Hispanic or Latino; a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origins, regardless of race?)

❑ Yes- Hispanic/Latino ❑ No- Other ❑ Unknown/Declined

**Race:** (If answered "No" above, check one of the descriptions below corresponding to the racial group which you identify.)

❑ White, Not Hispanic/Latino
(A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

❑ Black/African American, Not Hispanic/Latino
(A person having origins in any of the Black racial groups of Africa.)

❑ Native Hawaiian/Other Pacific Islander, Not Hispanic/Latino
(A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

❑ Asian, Not Hispanic/Latino
(A person having origins in any of the peoples of the Far East, Southeast Asia, or the Indian subcontinent.)

❑ American Indian/Alaskan Native, Not Hispanic/Latino
(A person having origins in any of the peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)

❑ Two or more Races, Not Hispanic/Latino
(All persons who identify with more than one of the above five races.)

# Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2020


**Why are you being asked to complete this form?**

Because when we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.[I] To help us measure how well we are doing, we are asking you to tell us, if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for Alliance, Inc., your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

**How do I know if I have a disability?**

You are considered to have a disability if you have a physical or mental impairment, or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment, or medical condition.

Disabilities include, but are not limited to:

- Autism
- Blindness
- Cancer
- Deafness
- Diabetes
- Epilepsy
- Bipolar Disorder
- Cerebral Palsy
- HIV/AIDS
- Major Depression
- Muscular Dystrophy
- Schizophrenia
- Impairments requiring a wheelchair
- Intellectual Disability (Formerly Mental Retardation)
- Missing or Partially Missing Limbs
- Multiple Sclerosis (MS)
- Obsessive Compulsive Disorder
- Post-Traumatic Stress Disorder (PTSD)

**Please check one:**

❑ Yes, I have a disability, or previously had a disability

❑ No, I do not have a disability

❑ I do not wish to answer

Name: ____________________________________________ Date: ______________________

Signature: ________________________________________________________________________

# Voluntary Self-Identification of Disability



**Reasonable Accommodation Notice**

Federal law required employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

________________________________________

Print Name

[i] Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website, www.dol.gov/ofccp.

**Public Burden Statement:**
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take approximately five minutes to complete.