



Home of Life Community Development Corporation (HLCDC)
 4650 W. Madison Street
 Chicago, IL. 60644-3613
 Phone: 773-626-8655 Fax: 773-626-1387
 E-mail: info@homeoflife.org

APPLICATION FOR EMPLOYMENT

Name: _____ Date: _____

Address: _____
 Number and Street City State Zip

Home Telephone: () _____ Social Security #: _____ D.O.B. ____/____/____

Sex: [] Male [] Female Marital Status: [] Single [] Married [] Widowed [] Divorced

Position Applying for: _____ Salary Desired: _____

Date available to start? ____/____/____ Referred by: _____

Have you ever been employed by Home Of Life Community Development Corp? [] Yes [] No

If so, dates: _____

Do you have any relatives employed by Home of Life Community Development Corp? [] Yes [] No

Have you ever been convicted of an offense other than a minor traffic violation? [] Yes [] No

Do you have any physical or mental disability, which would interfere with your ability to perform the job you are seeking? [] Yes [] No

EDUCATIONAL BACKGROUND

ARE YOU A HIGH SCHOOL GRADUATE [] Yes [] No

Name Of High School: _____ City/State _____

Dates Attended: From: _____ to _____ Highest Grade Completed? _____

if you are not a high school graduate. do you have a GED [] Yes [] No Certificate # _____

College: LIST BELOW EACH COLLEGE OR UNIVERSITY YOU HAVE ATTENDED. BE SURE TO RECORD DATES AND CREDITS RECEIVED.

College/University	City/State	Dates Attended From/To	Number of Credit Hours Received? Type Received?	Major	Degree Received Date Received

* This agency, an equal opportunity employer, supports the Civil Rights Act of 1964, which prohibits discrimination on the basis of age, race, religion, marital status, color, sex, national origin or disability.

Other Direct, Unpaid Experience, with Children (Such as Scout Work, Sunday School Teacher):

Employment History

Date (From -To)	Name of Employer	Address	Position	Reason for Leaving	Salary/Hourly wage

References: (List at least three persons who are not related to you.)

Name	Address	Telephone	Relationship

Professional References: (List below two persons who know you in a professional capacity.)

Name	Address	Telephone	Relationship

How would you expect to contribute to the work and objectives of Home Of Life Community Development Corp.?

Physical Examination: _____ Last Examination (Date): _____
Name and Address of Examining Physician: _____

I do solemnly swear (or affirm) that all answers given and statements made on this application are true and complete to the best of my knowledge and beliefs. I have not knowingly withheld any facts or circumstances that would adversely affect my application. I authorize inquiry of all statements in this application. I understand that any false statements or deliberate omissions on this application may be cause for discharge if I am employed.

APPLICANT'S SIGNATURE: _____ DATE: _____

INFORMATION ON PERSON EMPLOYED IN A CHILD CARE FACILITY*

I. Employing Facility _____

Address _____
(Street and Number) (City) (Zip Code)

II. Person Employed _____
(Date of Birth)

Social Security Number _____ - _____ - _____ Phone _____

Home Address _____
(Street and Number) (City) (Zip Code)

III. **Employment** Date Employed: _____

Position for which employed (Check appropriate item):

- Executive, Superintendent, or Director
- Child Care Supervisor (child care institution)
- Child Care Worker (child care institution)
- Child Care Staff (group home)
- Child Welfare Supervisor (child welfare agency)
- Child Welfare/Licensing Worker (child welfare agency)
- Registered Nurse
- Teacher (residential facility)
- Housekeeping
- Licensed Practical Nurse (day care center only)
- Master Teacher
- Early Childhood Teacher (day care center)
- School-age Worker (day care center)
- Early Childhood Assistant (day care center)
- School-age Assistant (day care center)
- Substitute
- Cook
- Clerical
- Other: _____

IV. **Previous Employment** (Last ten years of employment)

From	To	Name and address of Employer	Type of Work and Title

V. **Other Direct, Unpaid Experience with Children** (Such as scout work, Sunday School teacher)

*This facility should retain copy for its records.

Report of Reference on File (At least three character and/or business, from persons not related to the employee)

Name of Reference	Address	Relationship

I. Educational Background (Circle the one item indicating highest grade completed)

Elementary Grade:

0 1 2 3 4 5 6 7 8

High School:

1 2 3 4

GED:

Yes No

Years of College (Undergraduate):

1 2 3 4

Years of Graduate Work:

1 2 3 4

College Degree: _____ Graduate Degree: _____

Name of School, College, or University last attended: _____

Other Special Training or Professional License (Specify): _____

Professional License Number: _____

Evidence of Educational Achievement on File: Yes No _____ (Explain)

II. Physical Examination

Last Examination (Date): _____

Name and Address of Examining Physician: _____

Health Clearance Report on File? Yes No _____ (Explain)

III. Certification of Employment

I, the employer, or authorized official of the employing facility, do hereby certify that the above-named person is employed in the position indicated and that, to the best of my knowledge is qualified for the position indicated, and employment is in accordance with minimum standards prescribed by the Department of Children and Family Services.

Signed: _____

Executive Director/Director: _____

AUTHORIZATION FOR BACKGROUND CHECK

READ INSTRUCTIONS ON REVERSE SIDE AND PRINT ALL INFORMATION

FOR EMPLOYEES/VOLUNTEERS OF CHILD CARE FACILITIES

1	<input type="checkbox"/> Employee	<input type="checkbox"/> Day Care Center	<input type="checkbox"/> Day Care Agency
	or	<input type="checkbox"/> Group Home	<input type="checkbox"/> Child Welfare Agency
	<input type="checkbox"/> Volunteer	<input type="checkbox"/> Child Care Institution/Maternity Center	<input type="checkbox"/> Youth Emergency Shelter

PERSONAL INFORMATION

Last Name/First Name/Middle Initial _____	Social Security Number _____ - _____ - _____
Maiden and/or Any Names Formerly Used (Last/First/Middle Initial) _____ _____	Telephone (Including Area Code) (____) _____ - _____ Have you lived outside of Illinois in the past 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
2 CURRENT ADDRESS: Street/Apt.#: _____ City: _____ State: _____ Zip Code: _____ County: _____	List all previous addresses for the past five (5) years. (Street/Apt.#/City/County/State/Zip Code) Dates From/To _____ _____ _____
Date of Birth (Month/Date/Year) Age Place of Birth (City and State) Citizenship (Country) _____ _____ _____ <input type="checkbox"/> USA <input type="checkbox"/> Other, Specify _____	Sex Height Ft. In. Weight (lbs.) Hair (color) Eyes (color) Skin Tone Race <input type="checkbox"/> M _____ _____ _____ _____ _____ _____ <input type="checkbox"/> F

AUTHORIZATION /CERTIFICATION

3	Have you ever been convicted of other than a minor traffic violation? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been indicated as perpetrator in a child abuse/neglect investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No If the answer to either of the above is yes, explain: _____ _____	
	I certify that I have read and understood the Authorization/Certification box on the back page of this form. SIGNATURE _____ DATE _____	
	<table style="width:100%;"> <tr> <td style="width: 50%; padding: 5px;"> BACKGROUND RESULTS Sex Offender Clearance: _____ CANTS Clearance: _____ Illinois State Police Clearance: _____ FBI Clearance: _____ Transfer Clearances: SO/CANTS: _____ ISP: _____ </td> <td style="width: 50%; padding: 5px;"> FOR CENTRAL OFFICE OF LICENSING USE SID# _____ Clear _____ Record _____ BC-03 Registered: _____ FBI Sent Out: _____ </td> </tr> </table>	BACKGROUND RESULTS Sex Offender Clearance: _____ CANTS Clearance: _____ Illinois State Police Clearance: _____ FBI Clearance: _____ Transfer Clearances: SO/CANTS: _____ ISP: _____
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TO BE COMPLETED BY EMPLOYER

This authorization form will not be processed without completion of this section.

4	Date Fingerprinted: _____	Name of Facility Contact _____
	Full Name of Facility _____	_____
	Provider ID # _____	Phone Number of Facility Contact (____) _____ - _____
	Street Address: _____	_____
	City _____ IL ZIP: _____	_____

**INSTRUCTIONS FOR COMPLETION OF
CFS 718-E - AUTHORIZATION FOR BACKGROUND CHECK**

WHO SHOULD USE THIS FORM: This form must be completed by employees or volunteers who work in a day care center, day care agency, group home, child welfare agency, child care institution/maternity center or youth emergency shelter. Employees of day care homes, foster care homes and group day care homes are to use form CFS 718.

Do not send a request for a Child Abuse/Neglect Tracking System (CANTS) check to Central Licensing until the person has been fingerprinted.

SECTIONS 1, 2 AND 3 - COMPLETION OF IDENTIFICATION INFORMATION

Employer must instruct every person subject to a background check to complete the first three sections identifying the type of facility and what role they will have at the facility and all personal information. All identifying information must be accurate and complete.

PRINT ALL INFORMATION

- Name Current and all former names used by the individual must be included. If no other names, write "none."
- Social Security No. **THIS FORM WILL NOT BE PROCESSED WITHOUT A COMPLETE SOCIAL SECURITY NUMBER**
- Address Current and all addresses, including county, where the person has lived in the past five years
(If outside of Illinois, check appropriate box)
- Race : Enter all codes that apply
- | | |
|----------|---|
| BL/AA | Black or African American |
| WHITE | White |
| AI/AN | American Indian or Alaskan Native |
| ASIAN | Asian |
| NH/PI | Native Hawaiian or Other Pacific Islander |
| UNDET | Undetermined |
| HISP ORG | Indicate whether the individual is of Hispanic origin |

Each Person must answer the question "Have you ever been convicted of other than minor traffic violation?" If yes, an explanation must be provided --- complete with date of the incident(s).

The person completing the identification information must sign and date page 1 of the authorization form.

SECTION 4 - EMPLOYER

The Authorization for Background Check must be submitted to the employer for completion of Section 4 and to check the form and for completeness and accuracy before the employee is fingerprinted.

Employer must complete the following:

- Name of Facility Name of facility where employed.
- Street/City/Zip The site of licensed facility where person is employed.
- Provider ID # The Provider ID # is required. (The number which appears on the license certificate for the facility.)

AUTHORIZATION/CERTIFICATION

I AUTHORIZE THE Illinois Department of Children and Family Services to conduct an investigation to determine whether I have ever been charged with a crime and, if so, the disposition of those charges. I authorize the Department to request information and assistance from the U.S. Justice Department and the Illinois Law Enforcement in the conduct of this investigation. I authorize the Department to periodically search the Child Abuse and Neglect Tracking System to determine whether I have been a perpetrator of an "indicated" incident of child abuse or neglect pursuant to the Abused and Neglected Child Reporting Act. The child abuse and neglect background check and the criminal history investigation may be used for considering an application for license, current or prospective employment, or service as a volunteer in a child care facility. Persons 13-17 years of age signing this form authorize a search of CANTS only and are not subject to fingerprinting.

I understand that information obtained as a result of my authorizing this investigation is confidential and may be shared with my employer, prospective employer or with licensing staff only in accordance with applicable state and federal law and DCFS Regulations. I further certify that the information provided on this form is true and correct. I acknowledge that falsification of any information provided above and/or the results of the background check may be full and sufficient grounds to deny my application for licensure or may result in the termination of my employment.