

APPLICATION FOR EMPLOYMENT

This Township is an equal opportunity employer and will not discriminate against any applicant on the basis of any characteristic that is protected by state or federal law. Michigan law requires that a person with a disability or handicap requiring accommodation to perform the essential duties of the job must notify the employer in writing within 182 days of the date that the need is known or should have been known. Federal law has no such requirement.

Position Applied For: _____

Date Of Application: _____

Date You Can Start: _____

Please note that this application will only remain active for 3 months, after which the applicant would need to re-apply.

Name: _____
Last First Middle

Social Security #: _____

Present Address: _____
Street City State Zip

Permanent Address: _____
Street City State Zip

Telephone #: Home (_____) _____

Work (_____) _____

Are you 18 years or older? Yes _____ No _____

Are there any hours or days of the week you cannot work? _____

If so, when? _____

Type of Employment: Full-time _____ Part-time _____

Salary/ Wage Desired _____

Have you ever applied to this Township before? _____

Where? _____

Under what name? _____

When? _____

EDUCATION:

	NAME AND ADDRESS OF SCHOOL	NO. OF YEARS ATTENDED	DID YOU GRADUATE?	SUBJECT/ MAJOR
Elementary School				
High School				
College				
Specialized Training				

Do you have US Military experience? _____ Date Entered _____

Branch: _____ Rank: _____ Date Discharged _____ Honorably? _____

Are you lawfully entitled to be employed in the United States? _____

Have you ever been convicted of a crime except a minor traffic violation? Yes _____ No _____

(The response to this question will be considered in the context of its job-relatedness only.)

If so, please state citation, date and place where offense occurred. _____

Please provide any additional information such as special skills, training, management experience, equipment operation or qualifications you feel will be helpful to us in considering your application.

References: Three individuals not related to you, whom you have known for at least one year:

NAME	ADDRESS AND TELEPHONE	RELATIONSHIP	YEARS ACQUAINTED

Emergency Contact:

Name	Address	City	State/Zip	Telephone No.

CURRENT AND MOST RECENT FORMER EMPLOYERS: (Most Recent One First)

DATE MONTH/YEAR	NAME, ADDRESS AND TELEPHONE NO. OF EMPLOYER	SALARY: STARTING/ ENDING	LAST POSITION HELD/ RESPONSIBILITIES	REASON FOR LEAVING
From: To:				
From: To:				

May We Contact The Employers Listed? _____ Yes _____ No

If not, which one(s)? _____

Please read the following statement carefully before signing to indicate your understanding:

I understand that, prior to being offered employment; I may be requested to take an employment examination. In the event that I have a disability that will affect my ability to take the test, I will so inform the Township prior to the administration of the test so that a reasonable accommodation can be made. The Township reserves the right to require medical documentation regarding the need for accommodation.

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements or omitted information on this application may result in termination.

I understand and agree that, if hired, my employment is for no definite period and may, regardless of the date of payment of my wages and salary, be terminated with or without cause, at any time, with or without notice.

I authorize investigation of all statements contained in this application for any employment-related purpose. I release the listed references and all employers, except those specifically excepted,* to provide you with any and all applicable information they may have. I hereby release these references and former employers from all liability for any information they may give to you.

As a condition of employment, employees of the Township agree not to commence any action, claim, or suit relating to their employment with the Township more than 182 calendar days after the date the employee knew or should have known that a claim existed or later than the applicable limitations period established by statute, whichever is less.

Date

Signature

*Employers specifically accepted: _____

For Employer Use Only

Interviewed By: _____ Date: _____ Hired: ___ Yes ___ No

Starting Date: _____ Position: _____

Wage: _____