CHILDREN'S AID AND FAMILY SERVICES

200 Robin Road
Paramus, New Jersey 07652
201.261.2800
www.cafsnj.org
EQUAL OPPORTUNITY EMPLOYER

APPLICATION FOR EMPLOYMENT

GENERAL INSTRUCTIONS

A. Complete both pages of this form
B. Answer all questions accurately and completely
C. Notify our office promptly of any change of address
D. False statements are cause for rejection of this application, removal of Name from eligible list, or dismissal from a position.

APPLICATIONS ACCEPTED FOR OPEN ADVERTISED POSITIONS ONLY.

POSITION APPLIED FOR (exact title): ____________

Note: Children's Aid and Family Services is an "At Will" Employer
All Applicants will be required to furnish proof of identity and legal work authorization upon

How did you hear of this agency?	Resume Attached? Yes ☐ No ☐
Have you previously interviewed for any position in this agency before? Yes ☐ No ☐	Salary Requirement: $

1. Name: ____________ (Last) (First) (Middle Initial) Address: ____________ (Number and Street) ____________ (City) (State) (Zip Code) ____________ (Contact Number) (E-mail Address)	5. Are you a previous employee of Children's Aid and Family Services? If yes, give dates: Yes ☐ No ☐ From: ________ To: ________ Dept./Program: ________ Position: ____________ 6. Do you know, or are you related to anyone working for Children's Aid and Family Services? Past or Present If yes, please provide below: Name: ____________ Relationship: ____________
2. Do you have a Valid Driver's License Yes ☐ No ☐ Has your license ever been suspended or revoked? Yes ☐ No ☐ If yes, explain below under item No. 12	7. Are you now or have you been involved in post-grad training? If yes, what programs: ____________ Do you hold a current valid NJ Professional License? Yes ☐ No ☐ If yes, list below under item No. 12
3. If hired can you provide documentation that you are of working age? Yes ☐ No ☐	8. Is there any reason why you cannot perform the requirements of the job as described? Please explain under item No. 12 Yes ☐ No ☐
4. Can you, upon employment provide documentation establishing your identity and eligibility to work in the United States? Yes ☐ No ☐	9. **EDUCATION:** Do you have a high school diploma? Yes ☐ No ☐ Do you have a GED? Yes ☐ No ☐ N/A ☐ Name and address of high school or GED/Issuing Agency: ____________

SCHOOL	NAME & ADDRESS	DID YOU GRADUATE	MAJOR COURSE OF STUDY	CERTIFICATE/DEGREE
Jr. College, Technical or Vocational School		Yes ☐ No ☐		
College or University		Yes ☐ No ☐		
Graduate School		Yes ☐ No ☐		

You will be required to provide the agency with official transcript(s) from your school and allow us to make copies of relevant license(s) and/or certification(s).

11 A. Languages Spoken:	11 B. Software Applications:

12. Remarks:

13. **EXPERIENCE**: Please account for all employment within the last ten (10) years, including military services beginning with your current or most recent employer. In addition, list any other experience that is relevant to the position for which you are applying. You may include volunteer experience and internships. Resumes are required and are not a substitute for this form. You may attach additional sheets as needed. ***Note: Failure to complete this form in its entirety may lead to the disqualification of your application.***

From (Mo/Yr)	Title of Position	Company Name	Phone	Name of Immediate Supervisor
To (Mo/Yr)	Address – Number and Street City State Zip			Reason for Leaving
Description of Duties:				
Hours Worked Per Week				
Type of Business:				

From (Mo/Yr)	Title of Position	Company Name	Phone	Name of Immediate Supervisor
To (Mo/Yr)	Address – Number and Street City State Zip			Reason for Leaving
Description of Duties:				
Hours Worked Per Week				
Type of Business:				

From (Mo/Yr)	Title of Position	Company Name	Phone	Name of Immediate Supervisor
To (Mo/Yr)	Address – Number and Street City State Zip			Reason for Leaving
Description of Duties:				
Hours Worked Per Week				
Type of Business:				

From (Mo/Yr)	Title of Position	Company Name	Phone	Name of Immediate Supervisor
To (Mo/Yr)	Address – Number and Street City State Zip			Reason for Leaving
Description of Duties:				
Hours Worked Per Week				
Type of Business:				

NOTE: If you need to add more information regarding your experience, you may attach plain sheets and use the format shown above

I CERTIFY THAT ALL STATEMENTS ON THIS FORM ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I hereby authorize the Human Resources Department to verify any of this information to determine my capabilities for employment, and authorize release of information from my previous employers concerning my job performance. I understand that any statement found not to be materially correct constitute grounds for my dismissal.

____

PRINT NAME SIGNATURE DATE

APPLICATION MUST BE SIGNED AND DATED TO BE ACCEPTED FOR PROCESSING

*Employees working directly with children will be required to submit a health certification from their physician and the results of a Mantoux test.

* All employees will be required to submit to a CARI and fingerprint check.

Human Resources:
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Applicant Screening Process

Children's Aid and Family Services conducts investigative background checks on applicants. This process may include requesting consumer reports and accessing public records, which may include driving records, worker's compensation claims, credit history, bankruptcy proceedings, criminal records, etc. from federal, state and other agencies. This information may include: names and dates of previous employers, reasons for termination of employment, work experience, accidents and any information relating to character, general reputation, personal characteristics, educational background, or any other information about an applicant that may reflect suitability for employment.

Children's Aid and Family Services reserves the right to conduct further investigations as deem necessary, both for determining suitability for hiring and continued employment.

Disclosure of Information

Have you had an allegation of child abuse, neglect or exploitation substantiated against you? Yes □ No □

Have you been adjudged civilly or criminally liable for abuse of a developmentally disabled person receiving services from the Department of Human Services or placed in a community resident regulated by the New Jersey Office of Licensing? Yes □ No □

Do you possess a valid driver's license? Yes □ No □

____________________________________ __________________________

Applicant Signature **Date**

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Authorization to Obtain a Motor Vehicle Report

Dear Applicant, Volunteer or Intern:

Please be advised that this agency requires a motor vehicle report for any individual who will have responsibility for the transportation of agency children or the use of an agency vehicle.

This service is provided to us by IntelliCorp. It is our intention to use the information obtained solely for the purpose of determining your qualifications for this position. By signing this form you are authorizing the release of your motor vehicle records and recognize that we may need to request additional reports on a quarterly basis.

____

Print Name

____

Signature

_________________________ __________ _______________

Driver's License Number | State | Expiration Date

____

Date

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Paramus, New Jersey 07652
Business: (201) 261-2800
www.cafsnj.org

Authorization to Release Information

I hereby authorize and consent to the release of information and records bearing on my personal history, academic records, job performance and convictions, if any, to Children's Aid and Family Services, Inc. The information will be used for the purpose of determining my qualifications for employment or volunteering.

Upon request, a copy of this signed statement may be furnished to the school, present or former employer, present or former employer, criminal justice agency, or other person furnishing such information or record.

Print Name: ______________________________

Signature: ______________________________

Address: ______________________________

____

____

Date: ____________________

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Professional References List

Please provide at least (4) four professional references that will:
(1) Furnish information regarding your work experience and/or education;
(2) Furnish information regarding your ability to perform the position applied for and;
(3) Furnish information regarding your suitability to work with children and or adolescents (if applicable to position).

May we contact your *references*? Yes □ No □

1. **Name:** ______________________
Organization: ______________________
Address: ______________________
____
Contact #: ______________________
____
Email Address: ______________________
Relationship: ______________________

2. **Name:** ______________________
Organization: ______________________
Address: ______________________
____
Contact #: ______________________
____
Email Address: ______________________
Relationship: ______________________

3. Name ______________________
Organization: ______________________
Address: ______________________
____
Contact #: ______________________
Fax #: ______________________
Email Address: ______________________
Relationship: ______________________

4. Name ______________________
Organization: ______________________
Address: ______________________
____
Contact #: ______________________
Fax #: ______________________
Email Address: ______________________
Relationship: ______________________

Rev. 03.2015

Applicant's Signature: **Date:** ______________________

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Authorization to verify **Employment**

Section I:

Applicant – Please Complete

Name: ______________________________
First Middle Last

Employer: ______________________________

Supervisor's Name: ______________________________

Position:
Location: ______________________________

____

Human Resources Phone # ____________ Fax # ____________

____

Dates of Employment: ____________ to ____________
Month Year Month Year

I authorize the verification of the above stated information.

Employee Signature ______________________________ Date ____________

Section II:

Employer

Is there any reason why applicant should not work with children/adolescents? ☐ Yes ☐ No

I certify that all the above information is correct.

____
Signature Date

Upon completion, please fax this completed form directly to HR at (201) 740-7089 or email to SMontero@cafsnj.org.

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Authorization to verify **Employment**

Section I:

Applicant – Please Complete

Name:

____
First Middle Last

Employer: ____

Supervisor's Name:

____

Position:
Location: ____

____

Human Resources Phone # ______________________ Fax # ______________________

____

Dates of Employment: ______________________ to ______________________
Month Year Month Year

I authorize the verification of the above stated information.

Employee Signature ______________________________ Date ______________

Section II:

Employer

Is there any reason why applicant should not work with children/adolescents? ☐ Yes ☐ No

I certify that all the above information is correct.

____
Signature Date

Upon completion, please fax this completed form directly to HR at (201) 740-7089 or email to SMontero@cafsnj.org.

Rev. 10.2023

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Motor Vehicle Report and Mandatory Drug Screening Input Form

Please enter information as it is displayed on your driver's license

Applicant's Name

First: ____________________ Middle Initial: ___________ Last: __________________________

Driving License Information

Driving License Number: ____

State of Driving License: ____

Driver's License Expiration Date: ____

Applicant Name (if different than driver's license): ______________________________________

Applicant's Contact Information

____ Address:

City: State: ____________ Zip: ______________ SS#:

Email Date of Birth: ______________________________ Address:

____

Note: ***Drug testing will only be scheduled for those individuals who have accepted an offer of employment.***

The Central Registry of Offenders Against Individuals with Developmental Disabilities

Employee/Volunteer Consent for Employers to Check Form

N.J.A.C. 10:44D

Please Complete the Following Information:

Employee/Volunteer Last Name: ________________________ First Name: __________________________________

Other Last/First Names Used: (please list any/all last names used, including maiden name, nicknames or other)

________________________________ ___________________________ _____________________________

D.O.B.: _________________________ Last Four (4) Digits of Social Security Number: ____________________

Agency/Facility Name: ____

In accordance with *N.J.S.A. 30:6D-73 et seq*., I understand that providing my employer/prospective employer with the above information is for the purpose of my employer/prospective employer conducting a check of my name/identity against the NJ Department of Human Services'(DHS) Central Registry of Offenders Against Individuals with Developmental Disabilities (Central Registry) for the purpose of working/volunteering at an agency/facility/program, licensed, regulated or contracted with the Department of Human Services.

I understand that while I am awaiting the results of the Central Registry check, I may not work unsupervised with individuals with developmental disabilities and that I must be accompanied by a senior staff member or supervisor in any activities involving individuals with developmental disabilities.

By signing this agreement, I attest that the information I have provided above is factual and correct and I can be terminated from employment/volunteering for failure to provide accurate information.

I further attest that I am currently not on the NJ DHS Central Registry of Offenders Against Individuals with Developmental Disabilities. I understand that if my name appears on the Central Registry, I may not be employed/allowed to volunteer in a program licensed, contracted or funded, directly or indirectly by the State of New Jersey to work with individuals with developmental disabilities.

I understand that also under *N.J.S.A. 30:6D-73 et seq*., in my capacity as an employee, caregiver or volunteer, in a program or facility licensed, regulated or contracted with DHS, or receiving state funding directly or indirectly, I am required to immediately report any/all allegations of abuse, neglect and/or exploitation against an individual with a developmental disability to the NJ Department of Human Services and that failure to do so, while having reasonable cause to believe such an act was committed, constitutes a disorderly persons offense. I understand that when making such a report, in good faith, I am immune from any civil or criminal liability that might otherwise attach from the act of making the report. I understand that in situations of discrimination or discharge from employment as a result of making a report in good faith, I may seek court relief for such actions.

I further understand that I am required to cooperate with investigations conducted by DHS or its designee(s). I have read and understand the above and hereby give my consent for my name to be checked against the Department of Human Services, Central Registry of Offenders Against Individuals with Developmental Disabilities.

____ _______________________ ______________

Employee/Prospective Employee/Volunteer Name (please print) Signature Date

Provider Agency Use Only .The above named individual has been checked against the Central Registry of Offenders Against Individuals with Developmental Disabilities in accordance with N.J.A.C. 10:44D

Listed on Registry Registry Check Performed By:______________________________ Date: _____________ Yes____ No____

Children's Aid and Family Services, Inc.

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200 Robin Road
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Fax: (201) 634-3672

MEDICAL CERTIFICATION

Note: All individuals must submit a medical certification (within 6 months) from his or her physician and the results of a "TB" test, e.g. Mantoux (within 1 year).

1. I have examined ____and find him/her in good physical health, free of communicable disease and poses no health risk to others in the workplace.

The Mantoux Skin Test (PPD) was administered on: ________________________ The Mantoux Skin Test results were read on: ________________________

This person's Mantoux Skin Test was: ☐ Negative ____ ☐ Positive (x-ray results attached)

____

Print Physician's Name

____

Physician's Address

____

Physician's Contact Number

____ ___________________________

Physician's Signature **Date**

Physician's Stamp: