

Calhoun County Disabilities and Special Needs Board
78 Doodle Hill Road
St. Matthews, SC 29135

Dear Applicant:

Please complete the **ENTIRE** application. The following items are required before your application can be processed.

Sign the Reference Form (do not fill it out) and list on the application at least **three (3) personal references** as well as **previous and current employers**.

It is very important that you have **COMPLETE ADDRESSES** (**street with number, city, state and zip**) for these references.

Complete the Authorization for Criminal Investigation (SLED check).

A current **10-year driving record**, your **Social Security Card**, your **South Carolina Driver's License** and your **original high school diploma which must be witnessed** are required for employment.

Complete the South Carolina Department of Social Services Consent to Release Information form **dated August 2013** as well as the S. C. Second Injury Fund Questionnaire (please check each question).

The I-9 Employment Eligibility Verification form **dated 3/8/2013** must be signed.

Once your information is processed we will need the following filled out by the Human Resources Personnel.

Direct Deposit Authorization
W-4 Form

Thank you.

Calhoun County Disabilities and Special Needs Board
78 Doodle Hill Road
St. Matthews, SC 29135
803-874-2664

Calhoun County Disabilities and Special Needs
935 A-B Wire Road
Gilbert, SC 29054
803-892-2115

CALHOUN COUNTY DISABILITIES AND SPECIAL NEEDS BOARD

78 Doodle Hill Road

St. Matthews, SC 29135

Phone: (803) 874-2664

EMPLOYMENT APPLICATION

(Typed or Print in Ink)

This application
is not intended to be
a contract of employment or
a warranty of benefits

Date of Application _____

NAME _____ SOCIAL SECURITY NO. _____
Last First Middle

ADDRESS _____
Street City County State Zip

TELEPHONE () _____ () _____
Home Business

POSITIONS APPLIED FOR: _____ IN CASE OF EMERGENCY, NOTIFY:

Available To Work: () Full Time NAME _____

() Part Time () Temporary () Permanent ADDRESS _____

PHONE _____

RELATIONSHIP _____

Could Begin Work: _____ Acceptable Salary Range: _____

Veteran of Military Service? () Yes () No If Yes, attach a copy of DD214

Do you possess a valid S.C. Driver's License? () Yes () No No. _____ Exp. Date _____

Have you ever been employed by this agency? () Yes () No If yes, when _____

Do you have relatives employed by this agency? () Yes () No If yes, when, give names and where assigned _____

May we contact your present employer about your application for employment with this agency? () Yes () No

HIGHEST EDUCATION LEVEL COMPLETED: (if multiple degrees, please list)

School and Location	Course of Study	Years Attended From/To	Certificates/ Degrees Received
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PROFESSIONAL CERTIFICATES OR LICENSES

Profession	Date of Current Cert. of License	State Issuing or Registered In	Date of First License or Reg.	Exam Reciprocity Yes No
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This agency is an equal opportunity employer, and selects the best matched individual for the job based upon job related qualifications, regardless of race, color, creed, sex, national origin, age, handicap or other protected groups under state, federal, or local Equal Opportunity Laws.

EMPLOYMENT EXPERIENCE

START WITH YOUR CURRENT OR LAST JOB. INCLUDE MILITARY AND VOLUNTEER SERVICE.

1. Employer _____ Supervisor _____ From: _____ To: _____
Address _____ Full Time () Part Time ()
Telephone No. _____ Your Job Title _____ Starting Salary: _____
Duties: _____ Ending Salary: _____
Reason for Leaving: _____

2. Employer _____ Supervisor _____ From: _____ To: _____
Address _____ Full Time () Part Time ()
Telephone No. _____ Your Job Title _____ Starting Salary: _____
Duties: _____ Ending Salary: _____
Reason for Leaving: _____

3. Employer _____ Supervisor _____ From: _____ To: _____
Address _____ Full Time () Part Time ()
Telephone No. _____ Your Job Title _____ Starting Salary: _____
Duties: _____ Ending Salary: _____
Reason for Leaving: _____

4. Employer _____ Supervisor _____ From: _____ To: _____
Address _____ Full Time () Part Time ()
Telephone No. _____ Your Job Title _____ Starting Salary: _____
Duties: _____ Ending Salary: _____
Reason for Leaving: _____

ATTACH RESUME IF AVAILABLE AFTER COMPLETION OF ABOVE

REFERENCES: Give name, address and phone number of three references who are not related to you and who are not previous employees.

Name

Address

Telephone No.

1. _____
2. _____
3. _____

CERTIFICATE OF APPLICANT (Read Carefully Before Signing)

I hereby certify that all statements made in this application are true, and I agree and understand that any misstatements of material facts herein will cause forfeiture of all my rights to employment with this agency. This agency is authorized to request a transcript where necessary to verify my education record and make whatever back ground investigation necessary for employment purposes. I have no objection to having my record cleared through state and federal law enforcement agencies. I further agree to a physical examination if such examination is required as a condition of employment. I certify that I have never been involved in a substantiated case of abuse or neglect.

Applicant's Signature: _____ Date: _____

APPLICANT'S PERSONAL STATEMENT

(To be completed in applicant's own handwriting)

Give your qualifications, experience, and personal reasons for applying for this position.

PLEASE DO NOT WRITE BELOW

Interviewed by: _____ Date: _____

REMARKS: _____

Social Security Number: _____

NOTE: The information requested in this section is not used to evaluate your application. This information is needed for personnel research.

SEX: Male ()
Female ()

RACE: (Check One)
() W - White (Not Hispanic)
() B - Black (Not Hispanic)
() H - Hispanic (Regardless of Race)
() A - American Indian & Alaskan Native
() O - Asian & Pacific Islander

Positions Applied For: _____

Date of Birth: _____
(Month) (Day) (Year)

Print Name: _____
(Last) (First) (Middle Initial)

Please check the source from which you first learned about this position:

- () Newspaper
- () Bulletin Board
- () Employee
- () Other _____

South Carolina Department of Social Services
CONSENT TO RELEASE INFORMATION

With my signature below, I consent for the South Carolina Department of Social Services to conduct a one-time search of the records indicated below to determine whether they contain information that I was the perpetrator of harm to a child and to release information found to the individual/organization named below.

I understand that the information provided may prove to be unfavorable to me. I agree to hold the South Carolina Department of Social Services and its staff harmless from liability associated with release of information requested on this form. If it appears to me that the information has not been updated or is otherwise inaccurate, I agree to notify the Department immediately.

SECTION I. Purpose for Request

- A. I am requesting a search of the Central Registry of Child Abuse and Neglect and the Department's database of records of Child Abuse and Neglect cases in connection with:
- ☐ becoming or remaining a foster parent or potential adoptive parent; or
 - ☐ becoming or remaining an employee of or a member of the state or a local foster care review board; or
 - ☐ becoming an employee or volunteer for the South Carolina Guardian ad Litem Program or Richland County CASA.
- B. ☐ I am requesting a search ONLY of the Central Registry of Child Abuse and Neglect for a purpose of EMPLOYMENT.

*** SECTION II. Mail Results To:**

CALHOUN COUNTY DSN BOARD

ATTN: CRYSTAL LARDIERI

78 DOODLE HILL ROAD

TEL. NO: 803-874-2664

SAINT MATTHEWS, SC 29135

SECTION III. Central Registry Check Fees: Please ☒ appropriate box and include payment. Check or Money Order (NO CASH).

- | | |
|--|--|
| <input checked="" type="checkbox"/> Non-Profit Entities.....\$8.00 | <input type="checkbox"/> Name Changes.....\$8.00 |
| <input type="checkbox"/> For-Profit Entities.....\$25.00 | <input type="checkbox"/> Other (Individuals, etc.).....\$8.00 |
| <input type="checkbox"/> State Agencies.....\$8.00 | <input type="checkbox"/> Private Adoption Investigations.....\$25.00 |
| <input type="checkbox"/> Schools.....\$8.00 | |

SECTION IV. Please print legibly or type the following: First, Middle and Last Name (NO INITIALS)

Name: _____ DOB: _____ Sex: _____ Race: _____

Maiden/Aliases: _____ Name Change: _____

Place of Birth: _____ SSN: (See instructions) _____

Current Address: _____ Previous Address: (See instructions) _____

SECTION V. Your signature MUST be witnessed or notarized. Please mail appropriate payment and form for processing to: South Carolina Dept. of Social Services, ATTN: Cashier, 1535 Confederate Avenue, P.O. Box 1520, Columbia, SC 29202-1520.

Signature of Applicant

Date

Signature of Notary or Witness

Date

SECTION VI. RESULTS: THIS SECTION IS TO BE COMPLETED ONLY BY AUTHORIZED DSS EMPLOYEES OF THE DEPARTMENT.

- ☐ The name is not included as a perpetrator on the Central Registry of Child Abuse and Neglect.
- ☐ The request has been received. Additional research will be required to respond to the request. Thirty to sixty days may be required. Please call _____ if you have any questions.
- ☐ The name is included as a perpetrator on the Central Registry of Child Abuse and Neglect.
- ☐ The name is included as a perpetrator in the Department's database of records of child abuse and neglect cases. See attached correspondence.

Authorized DSS Employee

Date

INSTRUCTIONS FOR DSS FORM 3072 – CONSENT TO RELEASE INFORMATION

PLEASE DO NOT ALTER THIS FORM IN ANY WAY

SECTION I: Purpose for Request: To provide authorization for the SC Department of Social Services to conduct a search of the State Central Registry of Child Abuse and Neglect and/or the DSS Database and to release results. Please indicate the purpose of the search by checking ☒ in the appropriate box.

SECTION II: Mail Results To: Please ensure that you type or stamp the return address next to, "MAIL RESULTS TO," on this form. Please include the contact person's name and telephone number.

SECTION III: Central Registry Fee: Please check ☒ appropriate fee box.

SECTION IV: Please type or print legibly the following information:

- Name: Provide complete spelling of name to include the first, middle and last name - **NO INITIALS.**
- Name Change: List the new name(s).
- Date of Birth: Month/Day/Year
- Sex: (Self Explanatory)
- Race: (Self Explanatory)
- Social Security Number: All the information requested on this form is necessary in order to conduct a thorough search. Providing your Social Security Number (SSN) is optional, but it is recommended that you provide your SSN to assist with the research. Your SSN will be used **only** to conduct what we hope will be a thorough central registry/data base check and will not be given to any person than indicated agency or entity.
- Place of Birth: Provide the name of the State you were born in.
- Current Address: Provide your current residence.
- Previous Address: If current address is less than 7 years; list other addresses, States, Countries you have resided in for the past seven years. Use separate sheet if necessary.

SECTION V: Mail payment; completed Form 3072 Consent to Release Information, and a stamped addressed envelope to:

**South Carolina Department of Social Services
Attention: CASHIER
1535 Confederate Avenue
P.O. Box 1520
Columbia, SC 29202-1520**

- Signature of Applicant: Requesting the applicant's original signature for a one-time search of the State Central Registry of Child Abuse and Neglect and/or the DSS Database and to release results.
- Signature of Witness or Notary: The applicant's signature must be witnessed or notarized prior to submitting for processing.

PLEASE CALL (803) 898-7229 IF YOU NEED ASSISTANCE COMPLETING THIS FORM.

After receipt by cashier and processing of payment, the Central Registry/DATABASE check will be completed by authorized DSS personnel in the Division of Human Services.

DSS personnel in the Division of Human Services must do the following:

1. Conduct Central Registry check and/or Database search in accordance with Section I. A or B.
2. Check appropriate results box.
2. Sign and date form; stamp, "confidential" on envelope and mail to return address, Section II.

Distribution

Results of the search will be sent **ONLY** to the individual or organization specified in Section II of this form.

Calhoun County Disabilities and Special Needs Board
78 Doodle Hill Road
St. Matthews, SC 29135
803.874.2664 803.874.2660 fax

Authorization for Criminal Investigation

Abuse/Neglect Disclaimer

I do hereby give my authorization and consent for the Calhoun County Disabilities and Special Needs Board to perform a criminal investigation by SLED or the FBI.

I also certify that I have never been involved in a substantiated case of abuse or neglect.

√ Signature: _____

√ Date: _____

.....

To Applicant/Employee: Please fill in the following information which is needed to complete the criminal investigation.

√ Name: _____

√ Address: _____

√ City/State/Zip: _____

√ Social Security Number: _____

√ Drivers License #: _____

√ Date of Birth: _____

.....

For Office Use Only:

Account Number: _____

Job Classification: _____

CONFLICT OF INTEREST STANDARDS OF CONDUCT

The purpose of this section is to establish and implement a written code governing the members, employees, or agents. Within any organization, there will be times when potential conflicts of interests will be present. By following the policy described below, conflicts that are not in accordance with acceptable practices will be avoided.

All board members and members of the executive staff shall sign all statements regarding their understanding of these requirements regarding standards of conduct and conflicts of interest.

No employee, board member or agent of the board of the agency shall participate in vendor selection or in the award or administration of a purchase supported by funds from the S. C. Department of Special Needs, if a conflict of interest would be involved. Such a conflict would arise when:

- a) an employee, board member or agent
- b) any member of his or her family;
- c) his or her partner; or
- d) an organization, which employs or is about to employ any of the above has financial or other interest in the firm selected for the purchase.

The above statement does not prohibit awards to these parties, but does prohibit their participation in the selection process and in the administration of purchases where there would be a conflict of interest.

Employees, board members or agents are also prohibited from soliciting or accepting personal gratuities, favors or anything of monetary value from contractors/suppliers or parties to sub-agreements.

If applicable, please list below any potential conflicts.

Please sign on reverse side.

For more information, refer to the State Ethics Code, S. C. Code of Laws Section 8-13-10 through 8-13-1020 which governs disabilities and special needs boards. Contracting provider agencies, such as Calhoun County Developmental Corporation, Lawton Housing, Inc., and Calhoun County Housing, Inc., are also expected to follow the provisions of the State Ethics Code.

(www.statehouse.net/codet08c013htm).

I have read and am aware of the above.

Signature

Title

Date

H:Conflict of Interest



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

► **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation (Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][] - [][] - [][][][]		Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States (See instructions)	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. (See instructions)	
<p>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	<p>QR Code - Section 1 Do Not Write In This Space</p>

Signature of Employee	Today's Date (mm/dd/yyyy)
-----------------------	---------------------------

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		<div>Additional Information</div> <div>QR Code - Sections 2 & 3 Do Not Write In This Space</div>		
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

Signature of Employer or Authorized Representative <i>Crystal Lardieri</i>		Today's Date(mm/dd/yyyy)		Title of Employer or Authorized Representative Administrative Assistant	
Last Name of Employer or Authorized Representative Lardieri		First Name of Employer or Authorized Representative Crystal		Employer's Business or Organization Name Calhoun County DSN Board	
Employer's Business or Organization Address (Street Number and Name) 78 Doodle Hill Road		City or Town Saint Matthews		State SC	ZIP Code 29135

Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable)			B. Date of Rehire (if applicable)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	
C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.				
Document Title		Document Number	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.				
Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative	

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A		LIST B	LIST C
Documents that Establish Both Identity and Employment Authorization	OR	Documents that Establish Identity	Documents that Establish Employment Authorization
		AND	
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph	3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card	4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record	5. Native American tribal document
		6. Military dependent's ID card	6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card	7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document	8. Employment authorization document issued by the Department of Homeland Security
		For persons under age 18 who are unable to present a document listed above:	
10. School record or report card			
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		11. Clinic, doctor, or hospital record	
		12. Day-care or nursery school record	

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

SC SECOND INJURY FUND QUESTIONNAIRE

For the purpose of fulfilling the requirements of SC Code Ann. Section 42-9-400, your employer needs to know if, to the best of your knowledge, you have ever had any of the above following conditions:

	YES	NO		YES	NO	
(1)	{ }	{ }	Epilepsy	(17)	{ }	Anklosis of joints
(2)	{ }	{ }	Diabetes	(18)	{ }	Hyperinsulinism
(3)	{ }	{ }	Cardiac disease	(19)	{ }	Muscular dystrophy
(4)	{ }	{ }	Arthritis	(20)	{ }	Arteriosclerosis
(5)	{ }	{ }	Amputated foot, leg, arm, or hand	(21)	{ }	Thrombophlebitis
(6)	{ }	{ }	Loss of sight of one or both eyes or partial loss of uncorrected vision of more than 75% bilateral	(22)	{ }	Varicose Veins
(7)	{ }	{ }	Residual disability from Poliomyelitis	(23)	{ }	Heavy metal poisoning
(8)	{ }	{ }	Cerebral palsy	(24)	{ }	Ionizing radiation injury
(9)	{ }	{ }	Multiple sclerosis	(25)	{ }	Compressed air sequelae
(10)	{ }	{ }	Parkinson's disease	(26)	{ }	Ruptured disc
(11)	{ }	{ }	Cerebral vascular accident	(27)	{ }	Hodgkin's disease
(12)	{ }	{ }	Tuberculosis	(28)	{ }	Brain damage
(13)	{ }	{ }	Silicosis	(29)	{ }	Deafness
(14)	{ }	{ }	Psychoneurotic disability following treatment in a recognized medical or mental institution	(30)	{ }	Cancer
(15)	{ }	{ }	Hemophilia	(31)	{ }	Sickle-cell anemia
(16)	{ }	{ }	Chronic Osteomyelitis	(32)	{ }	Pulmonary disease
				(33)	{ }	Mental retardation
				(34)	{ }	Have you suffered from any other pre-existing disease, condition, or impairment that is permanent in nature? (If yes, please explain on back of form.)_____

I understand this questionnaire is for the purpose of enabling my employer to fulfill the requirements of the South Carolina Second Injury Funds, and it is in no way connected to the agency's decision to hire me. The information provided is not to be used by the agency as a basis of denying me placement within the agency or promotion, or to discriminate against me in any way. The information provided is true to the best of my information and belief. In the event of a future work related accident, my employer is authorized to request and review medical records pertaining to any of the conditions described herein as well as any records maintained by any government agency, past employer, or treatment facility with respect to any personal injuries I have received, and to discuss with my doctor other medical providers all facts learned during the course of my treatment.

Signed: _____ Date: _____
(Employee Signature)

Witness: _____ (Witness Signature)
I: Personnel

REFERENCE FORM

Applicant: Please complete only check-marked areas (✓)

Company: _____ Attention: _____

Address: _____

✓ Name of Applicant: _____

✓ Position Applied For: _____

Release and Waiver: Written Request for Reference

I authorize any source including present and former employers to furnish the Calhoun County Disabilities and Special Needs Board with whatever information they may have regarding my employment, including my reason(s) for leaving. I am signing this Release and Waiver voluntarily, and to request that you respond to this reference with full and complete information. Since this reference is an important part of my application for employment, I therefore waive and release all sources from any and all claims or causes of action in law or equity, including, but not limited to, defamation of character or invasion of privacy which might arise from responding to this reference check.

✓ *Applicant's Signature*

_____ Date

Personal Appraisal

(Based on your experience with applicant, please indicate by check mark in the appropriate column your evaluation of the following factors.)

	Above Average	Average	Unsatisfactory	Comments
Dependability				
Cooperation				
Initiative & Creativeness				
Emotional Stability				
Adjustability				
Consideration for Others*				

*Courteous in daily contact including attitude toward different race, religions, and nationalities.

	Yes	No
Do you have any knowledge of any behavior, activities, or association, which tends to show that this person is not reliable, trustworthy, and of good conduct and character?		
Do you have any knowledge of any physical or mental condition, which would adversely affect applicant's work performance?		
Do you have any knowledge that the candidate's performance on the job or off-duty conduct is adversely affected by the use of alcoholic beverages or drugs?		

NOTE: If the answer to any of the above questions is "Yes", please give full details on the back.

If you can give additional information regarding personal attributes or work performance, please do so below or on the back of this page.

Signature of Evaluator

Date

Employers: Please Complete

Date of Employment: _____ Title of Last Position: _____

Performance: _____

RESIGNED: _____ INVOLUNTARY: _____ ELIGIBLE FOR REHIRE? _____ OTHER: _____

Signature of Preparer/Date

Title

Please mail form to: **Calhoun County Disabilities and Special Needs Board, 78 Doodle Hill Road, St. Matthews, SC 29135**
or **Fax back to: 803-874-2660.** Thank you for your assistance in this matter.

REFERENCE FORM

Applicant: Please complete only check-marked areas (✓)

Company: _____ Attention: _____

Address: _____

✓ Name of Applicant: _____

✓ Position Applied For: _____

Release and Waiver: Written Request for Reference

I authorize any source including present and former employers to furnish the Calhoun County Disabilities and Special Needs Board with whatever information they may have regarding my employment, including my reason(s) for leaving. I am signing this Release and Waiver voluntarily, and to request that you respond to this reference with full and complete information. Since this reference is an important part of my application for employment, I therefore waive and release all sources from any and all claims or causes of action in law or equity, including, but not limited to, defamation of character or invasion of privacy which might arise from responding to this reference check.

✓ *Applicant's Signature*

_____ Date

Personal Appraisal

(Based on your experience with applicant, please indicate by check mark in the appropriate column your evaluation of the following factors.)

	Above Average	Average	Unsatisfactory	Comments
Dependability				
Cooperation				
Initiative & Creativeness				
Emotional Stability				
Adjustability				
Consideration for Others*				

*Courteous in daily contact including attitude toward different race, religions, and nationalities.

	Yes	No
Do you have any knowledge of any behavior, activities, or association, which tends to show that this person is not reliable, trustworthy, and of good conduct and character?		
Do you have any knowledge of any physical or mental condition, which would adversely affect applicant's work performance?		
Do you have any knowledge that the candidate's performance on the job or off-duty conduct is adversely affected by the use of alcoholic beverages or drugs?		

NOTE: If the answer to any of the above questions is "Yes", please give full details on the back.

If you can give additional information regarding personal attributes or work performance, please do so below or on the back of this page.

Signature of Evaluator

_____ Date

Employers: Please Complete

Date of Employment: _____ Title of Last Position: _____

Performance: _____

RESIGNED: _____ INVOLUNTARY: _____ ELIGIBLE FOR REHIRE? _____ OTHER: _____

Signature of Preparer/Date

_____ Title

Please mail form to: **Calhoun County Disabilities and Special Needs Board, 78 Doodle Hill Road, St. Matthews, SC 29135**
or **Fax back to: 803-874-2660.** Thank you for your assistance in this matter.

REFERENCE FORM

Applicant: Please complete only check-marked areas (✓)

Company: _____ Attention: _____

Address: _____

✓ Name of Applicant: _____

✓ Position Applied For: _____

Release and Waiver: Written Request for Reference

I authorize any source including present and former employers to furnish the Calhoun County Disabilities and Special Needs Board with whatever information they may have regarding my employment, including my reason(s) for leaving. I am signing this Release and Waiver voluntarily, and to request that you respond to this reference with full and complete information. Since this reference is an important part of my application for employment, I therefore waive and release all sources from any and all claims or causes of action in law or equity, including, but not limited to, defamation of character or invasion of privacy which might arise from responding to this reference check.

✓ *Applicant's Signature*

_____ Date

Personal Appraisal

(Based on your experience with applicant, please indicate by check mark in the appropriate column your evaluation of the following factors.)

	Above Average	Average	Unsatisfactory	Comments
Dependability				
Cooperation				
Initiative & Creativeness				
Emotional Stability				
Adjustability				
Consideration for Others*				

*Courteous in daily contact including attitude toward different race, religions, and nationalities.

	Yes	No
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