

TRAINING & TREATMENT INNOVATIONS, INC.

1225 E. Big Beaver Road, Troy, MI 48083
Phone (248) 524-8801 Fax (248) 524-8875

APPLICATION FOR EMPLOYMENT

We appreciate your interest in Training & Treatment Innovations, Inc. (TTI). The following information is required to help us make the best possible placement within TTI. A clear understanding of your background and work history will aid us in seeking to place you in a position which, in our judgment, best meets your qualifications. Please complete all portions of the application that pertain to you. You may complete this application now or return the completed application at a later time. You may show this application to any person of your choice. You must complete this application to be considered for employment. TTI is an equal opportunity employer and, in accordance with Federal, State, and Local laws, considers all qualified applicants regardless of race, color, sex, religion, national origin, sexual orientation, marital or veteran status, pregnancy (including childbirth or childbirth-related conditions), age, height, weight, genetic information, the presence of a medical condition or disability, or any other legally protected status.

PERSONAL INFORMATION					
First Name Middle Initial Last Name			Primary Telephone Number (Include area code)		
Home Address City State Zip+4 Digits			Home <input type="checkbox"/> Cell <input type="checkbox"/>		
Position Applied For: _____			Employment:		Hours:
Date Available: _____ Starting Salary: _____			<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Temporary		<input type="checkbox"/> Mornings <input type="checkbox"/> Days <input type="checkbox"/> Afternoons <input type="checkbox"/> Weekends
Have you ever been charged with abuse or neglect by a Federal State, Local Government, court or agency? Yes <input type="checkbox"/> No <input type="checkbox"/>			Alt. Telephone Number (Include area code)		
If yes, please explain. _____			Home <input type="checkbox"/> Cell <input type="checkbox"/>		
Has there ever been a Recipient Rights Violation Claim Filed against you? Yes <input type="checkbox"/> No <input type="checkbox"/>			Social Security Number		
Was it substantiated? Yes <input type="checkbox"/> No <input type="checkbox"/>			Are you over the age of 18 years old? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Are you a US citizen or are you authorized by the INS to Work in the USA? Yes <input type="checkbox"/> No <input type="checkbox"/>			How were you referred to us? Agency <input type="checkbox"/> Employee <input type="checkbox"/> If yes, who? _____ Ad <input type="checkbox"/> Other _____		
			Have you ever been convicted of Medicaid Fraud? Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Have you ever been denied bonding? Yes <input type="checkbox"/> No <input type="checkbox"/>		
EMPLOYMENT DESIRED					
Have you applied for employment here before? Yes <input type="checkbox"/> No <input type="checkbox"/>		Have you ever been employed here? Yes <input type="checkbox"/> No <input type="checkbox"/>			
When? Where?		When? Where?			
Are you willing to travel up to 25 miles from your Home to your work site? Yes <input type="checkbox"/> No <input type="checkbox"/>			Are you currently employed? Yes <input type="checkbox"/> No <input type="checkbox"/>		
			If so, may we contact your employer? Yes <input type="checkbox"/> No <input type="checkbox"/>		
			Are you currently laid off or on leave From another company? Yes <input type="checkbox"/> No <input type="checkbox"/>		
EDUCATION					
NAME OF SCHOOL	Location City State	Main Course of Study	Did you graduate?	Grade Average	Degree Earned
List any scholastic honors received and offices held while in school and all applicable skills and trainings.					
Are you planning to pursue other studies? Yes <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> No <input type="checkbox"/>					
If so, where and what course of study? _____					
Current Licensure/Certification:		License Number:		State Issued:	License Expiration Date:

Employers must make accommodations to disabled applicants and employees where the accommodation does not impose an undue hardship on the employer. Under Michigan law only, disabled employees and applicants may request an accommodation of their disability by notifying TTI in writing of the need for accommodation within 182 days of the date the disabled individual knows or should know that an accommodation is needed. This requirement does not apply to an individual's right under the Americans with Disabilities Act. Failure to properly notify TTI may preclude any claim that the employer failed to accommodate the disabled individual.

EMPLOYMENT HISTORY

List all employment for the past ten (10) years, starting with present job. Please include military experience.

**** ALL APPLICANTS MUST EXPLAIN ANY EMPLOYMENT GAP OF SIX (6) MONTHS OR LONGER
WITHIN THE LAST FIVE (5) YEARS (SEE BELOW) ****

Company Name	Specific Duties
Street Address	Telephone Number (Include area code)
City and State	Reason for leaving
Job Title	Dates Employed
Supervisor	Salary/Hourly Rate
Company Name	Specific Duties
Street Address	Telephone Number (Include area code)
City and State	Reason for leaving
Job Title	Dates Employed
Supervisor	Salary/Hourly Rate
Company Name	Specific Duties
Street Address	Telephone Number (Include area code)
City and State	Reason for leaving
Job Title	Dates Employed
Supervisor	Salary/Hourly Rate

****If you have a gap in employment of six (6) months or longer within the last five (5) years, please explain here:**

DRIVING EXPERIENCE

Do you have a valid Michigan Driver's License? <input type="checkbox"/> Yes <input type="checkbox"/> No License # _____ Exp. Date _____	Type of License <input type="checkbox"/> Operator <input type="checkbox"/> CDL <input type="checkbox"/> Chauffeur	Type of Auto Insurance <input type="checkbox"/> Full Coverage <input type="checkbox"/> PLPD
Have you ever had your Driver's License suspended or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____	Have you ever been involved in an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____	

EMERGENCY CONTACT

(In case of an emergency, please notify nearest living relative)

Name	Relationship	Phone Number
Address		

PLEASE READ BEFORE SIGNING

PLEASE INITIAL next to each statement, verifying that you have read and agree to the terms of this application.

_____ I certify that all statements made by me on this application are true and complete to the best of my knowledge and that I have withheld nothing which, if disclosed, would affect this application unfavorably.

_____ I authorize my previous employers, schools or persons named as references to give any information regarding employment or educational record. I also authorize Training & Treatment Innovations, Inc. to investigate my background relating to employment at this agency. I agree that this company and my previous employers shall not be held liable in any respect if a job offer is not extended, is withdrawn or my employment is terminated because of false statements, omissions or answers made by me on this application. In the event I am chosen for employment with this company, I will comply with all rules and regulations as set forth in any communication distributed to employees.

_____ I certify that I am not bound by any non-compete agreement or other restrictive covenant, which would disqualify or prevent me from becoming employed by the Company or performing any duties contemplated by my employment.

_____ I understand that if my position requires professional licensure, (i.e. LMSW, LLMSW, LBSW, LLBSW, LPC, LLPC, etc.) I acknowledge that it is my responsibility to maintain an unexpired, valid license at all times during my employment with Training & Treatment Innovations, Inc.

_____ In compliance with the Immigration Reform and Control Act of 1986, I understand that I will be required to provide approved documentation that verifies my right to work in the United States on my first day of employment, a valid Michigan driver's license, proof of vehicle insurance and registration, a copy of my social security card, certified copy of educational credentials, copies of state licensure (if applicable), and a copy of a negative TB test.

_____ I agree that should an offer of employment be extended, that I shall be bound by the policies, rules, regulations and conditions of employment of Training & Treatment Innovations, Inc. I further acknowledge that the agency policy and a procedure manual are available for my review and are maintained in the office of my supervisor.

PLEASE READ BEFORE SIGNING (cont'd.)

PLEASE INITIAL next to each statement, verifying that you have read and agree to the terms of this application.

_____ I further understand and agree that my employment is for no definite period of time and may, regardless of the day of payment of wages or salary, be terminated for any reason and at any time without previous notice. No amendment or exception to this at-will status can be made at any time, for any reason, except by the Company's President and it must be in writing, directed to you personally, and signed by him or her. Training & Treatment Innovations, Inc. is an "At Will Employer".

_____ I agree that any action, suit, or charge against the Company, arising out of my employment or termination of employment, including, but not limited to, claims arising under State and Federal law, but not Federal civil rights statutes containing a separate limitations period, must be brought within 180 days of the event giving rise to the claims or be forever barred unless the applicable statute of limitations period is shorter than 180 days in which case I will continue to be bound by the shorter limitations period. I waive any limitation periods to the contrary. I further agree that if I should bring any non-statutory claim action or claim arising out of my employment against the Company, in which the Company prevails, I will pay to the Company any and all such costs incurred by the Company in defense of said claims or actions, including attorney fees. I also agree that all such claims shall be decided by a judge and not a jury. I specifically waive my right to have a jury decide the outcome of any such claims. This jury waiver and shortened statute of limitations period shall apply to any claim against the Company, its parent, subsidiaries, affiliates, successors and assigns and its/their current or former employees, members, directors, officers, or agents.

I hereby acknowledge that I have read and understand the above statements.

Signature _____ Date _____

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PROFESSIONAL EMPLOYMENT REFERENCE COVER SHEET

Applicant's Name: _____

Position Desired: _____

I give my permission to Training & Treatment Innovations, Inc. to receive complete employment information as requested from the people or agencies that I have listed below. I understand that this information is strictly confidential, and that by signing this form, I waive my right to the information provided by these references. I also hereby release any entity and individual completing this form from any and all claims and causes of action which could arise from the information given or provided in response to this form.

Signature of Applicant: _____ Date: _____

Please list three (3) **PROFESSIONAL** references below including their full name and title, address, city, state, zip code and current phone number. If your reference would like to be contacted via email, please provide their preferred email address.

Name & Title: _____
Company: _____
Street Address: _____
City, State, Zip: _____
Phone Number: _____ () _____
Email Address: _____

Name & Title: _____
Company: _____
Street Address: _____
City, State, Zip: _____
Phone Number: _____ () _____
Email Address: _____

Name & Title: _____
Company: _____
Street Address: _____
City, State, Zip: _____
Phone Number: _____ () _____
Email Address: _____

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REFERENCE EVALUATION

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Signature of Applicant: _____

Date: _____

Evaluator: Please complete all areas below.

- 1. How long have you known this applicant? _____
- 2. In what capacity have you known this applicant? _____

3. Please give your appraisal of the applicant on each of the following with a check mark:

	Outstanding	Very Good	Satisfactory	Poor
A. Leadership	_____	_____	_____	_____
B. Working relationship with Other professionals	_____	_____	_____	_____
C. Skill working with people	_____	_____	_____	_____
D. Openness to change & new ideas	_____	_____	_____	_____
E. Concern for the needs of others	_____	_____	_____	_____
F. Performance under stress or during crisis time	_____	_____	_____	_____
G. Judgment in decision making	_____	_____	_____	_____
H. Oral Communication skills	_____	_____	_____	_____
I. Written communication skills	_____	_____	_____	_____
J. Creativity	_____	_____	_____	_____
K. Integrity	_____	_____	_____	_____
L. Reliability	_____	_____	_____	_____
M. Resourcefulness	_____	_____	_____	_____
N. Ability to be a team player	_____	_____	_____	_____

What do you see to be this applicant's greatest strengths? _____

Please add any pertinent comments which will assist in assessing the applicants' probability of success with our program: _____

If you are unable to provide the requested information please list dates of employment and whether your agency would or would not re-hire this individual: _____

Signature of Person Completing This Evaluation _____

Date _____