



**BOYS & GIRLS CLUB  
OF JEFFERSON CITY**

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1105 Lafayette Street, Jefferson City, MO 65101 Telephone Number (573) 634-2582, Fax (573) 638-0350

# Employment Application

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please submit a copy of your Social Security card *or* Birth Certificate *and* a copy of your Driver's License along with this application.

## FOR OFFICE USE ONLY

Date of interview: \_\_\_\_\_

Hire Date:	Site:

PERSONAL INFORMATION					
NAME (Last)	(First)	(M)	TELEPHONE NUMBER(S)		
OTHER NAMES USED			EMAIL ADDRESS		
PRESENT ADDRESS					
PERMANENT ADDRESS, IF DIFFERENT					
ARE YOU AUTHORIZED TO WORK IN THE UNITED STATES? ___ YES ___ NO			ARE YOU AT LEAST 18 YEARS OLD? ___ YES      ___ NO		
HOW WERE YOU REFERRED TO BOYS & GIRLS CLUB OF THE CAPITAL CITY?					
PREVIOUS EMPLOYMENT WITH BOYS & GIRLS CLUB (if any, give dates, position, location)					
RELATIVES EMPLOYED BY BOYS & GIRLS CLUB OF THE CAPITAL CITY (if any, give dates, position, location)					
HAVE YOU BEEN CONVICTED OF, PLED GUILTY TO, AND/OR PLED <i>NOLO CONTENDRE</i> TO A CRIME (FELONY OR MISDEMEANOR, INCLUDING BUT NOT LIMITED TO SEXUAL OFFENDER CRIMES, THEFT, BANKING FRAUD, DRUG AND/OR ALCOHOL-RELATED OFFENSES, ASSAULT, ETC.)? If yes, please give place of occurrence, state, date, court, type of crime, disposition)  ___ YES _____  _____  ___ NO _____  <i>Note: Conviction of a crime will not necessarily disqualify you for employment. Each conviction will be judged on its own merit with respect to time and relevance to the job position.</i>					
EMPLOYMENT DESIRED					
TITLE OR CATEGORY			SALARY REQUIREMENTS		
DATE AVAILABLE			DO YOU HAVE TRANSPORTATION OR WILL YOU WALK?		
Are you seeking employment:  ___ Full-Time      ___ Part-Time      ___ Temporary      ___ Summer					
EDUCATION					
SCHOOL	NAME & LOCATION	MAJOR	GRADUATE? YES      NO		DEGREE
HIGH SCHOOL					
COLLEGE OR UNIVERSITY					
OTHER SCHOOLS (e.g. Graduate, technical, military)					

**WORK HISTORY**

*Start with current or last employer first. Do not detail duties and responsibilities if described in attached résumé.*

<b>COMPANY NAME</b>		YOUR TITLE	
COMPANY ADDRESS			
START DATE	END DATE	STARTING SALARY	ENDING SALARY
SUPERVISOR'S NAME	SUPERVISOR'S TITLE	TELEPHONE NUMBER	MAY WE CONTACT EMPLOYER?
BRIEFLY DESCRIBE YOUR DUTIES & RESPONSIBILITIES			
REASON FOR LEAVING			
<b>COMPANY NAME</b>		YOUR TITLE	
COMPANY ADDRESS			
START DATE	END DATE	STARTING SALARY	ENDING SALARY
SUPERVISOR'S NAME	SUPERVISOR'S TITLE	TELEPHONE NUMBER	MAY WE CONTACT EMPLOYER?
BRIEFLY DESCRIBE YOUR DUTIES & RESPONSIBILITIES			
REASON FOR LEAVING			
<b>PLEASE PROVIDE ANY RELEVANT WORK OR VOLUNTEER EXPERIENCE DEALING WITH CHILDREN.</b>			
Company Name:			
Your Title:			
Start Date/End Date:			
Supervisor Name/Title/Telephone Number:			
Reason for leaving:			

PLEASE PROVIDE ANY RELEVANT WORK OR VOLUNTEER EXPERIENCE DEALING WITH CHILDREN.
Company Name:
Your Title:
Start Date/End Date:
Start Date/End Date:
Supervisor Name/Title:
Reason for leaving:

REFERENCES		
Name	Contact	Relationship

### **AUTHORIZATION TO RELEASE EMPLOYMENT REFERENCE INFORMATION**

I understand that Boys & Girls Club of the Capital City (BGCC) will attempt to verify statements made on my application and made during my employment interview. I understand that the Boys & Girls Club of the Capital City must perform a criminal background check on me because I will be working with and around children. I hereby give my permission for my former employers to answer any and all questions based upon information available to them in my prior employment records. I understand that it is possible that my prior employment records may not be accurate. Nonetheless, in consideration of BGCC's review of this application and my candidacy for employment, I release BGCC and all former employers from any liability as a result of the furnishing and receiving of this reference information. I understand that my failure to sign this reference release so BGCC can contact references and make a full background check of my previous work history will be deemed interference with and a withdrawal of my application for employment.

(\*Place your **INITIALS** in the appropriate space to indicate and document your consent to this authorization.)

\_\_\_\_\_ Yes      \_\_\_\_\_ No

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### **JOB APPLICANT AGREEMENT**

I understand that BGCC requires certain information about me to evaluate my qualifications for employment and conduct its business if I become an employee. I understand that false, incomplete, or misleading statements on this application or my résumé may be considered sufficient cause for rejection of my application and for dismissal, if discovered after I am employed by BGCC. The use of this application blank does not indicate there are positions open and does not in any way obligate BGCC.

I also authorize BGCC to supply information about my employment record, in whole or in part, in confidence to any prospective employer, government agency, or other party having a legal and proper interest, and I hereby release BGCC from any and all liability for its providing this information. I understand that I have the right to make a written request within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of this investigation.

In consideration of my potential employment, I agree to conform to the rules of Boys & Girls Clubs of America (BGCA). I understand that I have the right to terminate my employment at any time with or without notice, with or without cause, and that BGCC has a similar right. I understand my employment by BGCC does not constitute a guarantee that any position be continued for any length of time or that any job assignment or shift be permanent. I understand that I may be required to work scheduled and unscheduled overtime and scheduled weekend and holiday work when required by BGCC. I also understand that BGCC has the right to modify its policies without giving me any notice of the changes. No promises regarding employment have been made to me. I understand that no one other than the Board of Directors of the BGCC has authority to make any other agreement.

The Immigration Reform and Control Act of 1986 require that, after employment, employers verify the legal work authorization and identity of all new employees. An offer of employment will depend upon BGCC's ability to verify this necessary information.

Applications will not be considered active after the position is filled. I understand that BGCC will attempt to verify statements made on my application and made during my employment interview.

I hereby acknowledge that I have read and understand the preceding statements

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**EQUAL OPPORTUNITY EMPLOYER.** Qualified applicants receive consideration for employment without discrimination because of age, sex, religion, marital status, race, color, creed, national origin or disability. (Revised 2/14/08 WHP)

**SAMPLE COMBINED DISCLOSURE AND AUTHORIZATION:** *As the employer or end-user of consumer reports, it is your responsibility to ensure compliance with all of the relevant federal, state and local laws governing this area. [If you are located in California or obtain consumer reports on California residents, please refer to [www.fadv.com/legal/ca](http://www.fadv.com/legal/ca) also you may request a copy of our Sample CA Disclosure and Authorization Form]. We strongly recommend that prior to use, you consult with an attorney.*

**COMBINED DISCLOSURE NOTICE AND AUTHORIZATION REGARDING  
BACKGROUND CONSUMER REPORTS**

**Important: Please read carefully before signing.**

**DISCLOSURE**

A consumer report and/or investigative consumer report including information concerning your character, employment history, general reputation, personal characteristics, police record, criminal records, education, qualifications, motor vehicle record, mode of living and/or credit and indebtedness may be obtained in connection with your application for and/or continued employment with the employer. **A consumer report and/or an investigative consumer report may be obtained at any time during the application process or during your employment with the company.** These reports may include experience information along with reasons for termination of past employment. Further, understand that information from various Federal, State, local and other agencies which contain your past activities may be requested. A consumer report containing injury and illness records and medical information may be obtained after a tentative offer of employment has been made.

The name, address and telephone number of the Company preparing the report is: First Advantage P.O. Box 3367 Seminole, FL 33775-3367; Toll free number: 1-800-321-4473 ext. 8. Their privacy Policy can be reviewed at <http://www.fadv.com/privacy-policy>.

Before any adverse action is taken, based in whole or in part on the information contained in the consumer report, you will be provided a copy of the report, the name, address and telephone number of the reporting agency, and a summary of your rights under the Fair Credit Reporting Act.

For California, Minnesota or Oklahoma applicants only, if you would like to receive a copy of the consumer report, if one is obtained, please check this box. ☐ If checked and you are a California applicant, a copy of the consumer report will be sent within three (3) days of the employer receiving a copy of the consumer report.

For California applicants only, if public record information about your character, general reputation, personal characteristics, and mode of living is obtained without using a consumer reporting agency, you will be supplied a copy of the public record information within seven (7) days of the employer's receipt unless you check this box where you hereby wave your right to obtain a copy of the investigative consumer report ☐.

Please be advised that you have a right to inspect the files that the Consumer Reporting Agency may have on you during normal business hours and upon you furnishing proper identification.

## AUTHORIZATION

By signing below, you hereby authorize without reservation, any party or agency contacted by this employer to furnish the above mentioned information. You further authorize ongoing procurement of the above mentioned reports at any time during your employment (or contract). You also agree that a fax or photocopy of this authorization with your signature be accepted with the same authority as the original.

You hereby authorize and request, without any reservation, any present or former employer, school, police department, financial institution, division of motor vehicles, consumer reporting agencies, or other persons or agencies having knowledge about you to furnish First Advantage with any and all background information in their possession regarding you, in order that your employment qualifications may be evaluated.

**Print your Name:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Driver's License State:** \_\_\_\_\_ **License Number:** \_\_\_\_\_

*The following is for identification purposes only to perform the background check:*

**Date of Birth (MM/DD/YYYY):** \_\_\_\_\_ **Race:** \_\_\_\_ **Gender (M or F):** \_\_\_\_\_

**Other or Former Names:** \_\_\_\_\_

**Professional License:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Type:** \_\_\_\_\_ **Number:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_





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## WORKER REGISTRATION

### FCSR USE ONLY

Register online at [www.health.mo.gov/safety/fcsr](http://www.health.mo.gov/safety/fcsr) OR mail this form, copy of Social Security card, and payment to **Missouri Dept. of Health and Senior Services, Fee Receipts, PO Box 570, Jefferson City, MO 65102.**

#### REGISTRATION TYPE (Check all that apply. Complete column on right only if Long Term Care/Personal Care selected from left.)

- ☐ Adoptive Parent (Agency Name: \_\_\_\_\_)
- ☐ Child Care
- ☐ Foster Parent/Family Member of Foster Parent (County Office: \_\_\_\_\_)
- ☐ Hospital
- ☐ Long Term Care/Personal Care (Please choose subcategory at right →.)
- ☐ Mental Health/Psychiatric Hospital
- ☐ Voluntary (Select voluntary if no other registration type applies.)

A one-time registration fee of **\$12.00** applies to all categories except Foster Parents. Foster Parents must list the Children's Division county office.

Register only once. If you believe you have already registered, check our website at [www.health.mo.gov/safety/fcsr](http://www.health.mo.gov/safety/fcsr) or call, toll free, 866-422-6872.

#### SOCIAL SECURITY NUMBER (Mail copy of card with form.)

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#### Long Term Care / Personal Care

Subcategories (Complete if LTC/PC selected at left.)

- ☐ Adult Day Care
- ☐ Assisted Living Facility
- ☐ Hospice
- ☐ Hospital LTAC/Swing Bed
- ☐ Mental Health – Residential Facility/ICF
- ☐ Nursing Facility/Skilled Nursing
- ☐ Personal Care – Home Health
- ☐ Personal Care – In-Home Services
- ☐ Personal Care – Consumer Directed Services/Center for Independent Living
- ☐ Personal Care – HCY/PDW/DDD/Other

#### PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)

LAST NAME		FIRST NAME		MIDDLE NAME	SUFFIX (Jr., Sr., II, III)
MAIDEN NAME (If applicable)		PRIOR NAMES USED (If applicable, list first and last names.)		DATE OF BIRTH (mm-dd-yyyy)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F

#### CONTACT INFORMATION

MAILING ADDRESS (Enter your street address or post office box. This address must be different from Employer Address.)

CITY		STATE	ZIP CODE	COUNTY
TELEPHONE ( ) -	EMAIL ADDRESS (Required)		COUNTRY (Complete only if U.S. territory/outside U.S.)	

#### EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)

<input type="checkbox"/> My current/potential child care, long term care or mental health care employer is:				<input type="checkbox"/> No Employer, because I am a(n):	
EMPLOYER NAME				<input type="checkbox"/> Adoptive Parent	
EMPLOYER ADDRESS				<input type="checkbox"/> Foster Parent/Family Member	
EMPLOYER CITY		STATE	ZIP	<input type="checkbox"/> Home Child Care Provider	
EMPLOYER TELEPHONE ( ) -		EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE	<input type="checkbox"/> Private Pay/Private Duty	
				<input type="checkbox"/> Student	
				<input type="checkbox"/> Volunteer	
				<input type="checkbox"/> Other (Explain: _____)	

#### REGISTRATION AGREEMENT

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requester of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

**NOTICE:** The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT (Must be signed in blue or black ink.)

DATE OF SIGNATURE (Must be within six months of submission.)



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## WHAT IS THE FAMILY CARE SAFETY REGISTRY?

The Family Care Safety Registry (FCSR), administered by the Missouri Department of Health and Senior Services (DHSS), provides families and employers with a method to obtain background screening information. The Registry, through various state agencies, offers several resources to screen child care, long term care and mental health workers:

- State criminal history and sex offender registry records maintained by the Missouri State Highway Patrol
- Child abuse/neglect records maintained by the Missouri Department of Social Services
- The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
- The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
- Child care facility licensing records maintained by the Missouri Department of Health and Senior Services
- Foster parent records maintained by the Missouri Department of Social Services

## WHO HAS TO REGISTER?

Any person hired on or after January 1, 2001, as a child care worker or elder care worker, hired on or after January 1, 2002, as a personal care worker, or hired on or after January 1, 2009, as a mental health worker, as provided in §210.906, RSMo, is required to make application for registration in the Family Care Safety Registry within fifteen (15) days of the beginning of employment. **Such person who fails to submit a completed registration form to the DHSS without good cause, as determined by the department, is guilty of a class B misdemeanor.** Employees and volunteers from non-state and/or federally regulated entities are NOT REQUIRED to register with the FCSR.

## HOW DO I COMPLETE THE REGISTRATION FORM?

**Registration Type** – Check at least one box from the left column for type of registration that best describes your worker category. If no other type applies, select "Voluntary." (A "voluntary registrant" is a person who is not mandated to register with the Family Care Safety Registry pursuant to §210.900 *et seq.*, RSMo.) If you checked Long Term Care / Personal Care, please *also* make one or more selections from the column on the right for subcategory.

**Social Security Number** – You must provide your Social Security number pursuant to 19CSR 30-80.030(1). This identifying information, including Social Security number, will be used for internal identification purposes and to conduct background screenings for the resource information listed in paragraph one above.

**Personal Information** – List your current Last Name, First Name, Middle Name, and any suffix associated with your last name. List any other names by which you may have been known, including maiden names, past married names, and nicknames (attach additional sheets if needed). For identification purposes, list your gender and date of birth.

**Contact Information** – List your address, city, state, ZIP code, and county. Include your telephone number and email address. We will use this information to notify you of registration results and any background screenings conducted. Email notifications will be encrypted for improved security. To reduce postage costs, the Family Care Safety Registry may contact you to request a personal email address if one is not provided.

**Employer Associated with this Registration** - If you are currently employed by or are seeking employment with a child care or long term care provider, please list the facility name, address, telephone number, and contact person. If registration is not for employment purposes, make a selection from column on right.

**Registration Agreement** – Sign and date the registration form. Your signature will authorize the Family Care Safety Registry to conduct the background screening outlined in §210.903.2, RSMo and to provide the information to requesters for employment purposes, as provided in §210.921.1, RSMo.

## WHERE DO I SEND MY REGISTRATION FORM?

Send your completed registration form and photocopy of Social Security card and required fee to the **Missouri Department of Health and Senior Services, ATTN: Fee Receipts, P.O. Box 570, Jefferson City, MO 65102**. If you have questions, please call the Registry using the toll-free telephone number, **866-422-6872**.

## WHEN WILL I KNOW THE RESULTS OF MY BACKGROUND SCREENING?

After the background screening has been completed, you will be notified in writing of the results that will be recorded in the Family Care Safety Registry. You will also be notified in writing each time background screening information is provided. The notification will contain the name and address of the person who made the request and the background information disclosed. The person making the request will be informed that information will be released for employment purposes only, pursuant to §210.921.1, RSMo. Any person using Registry information for any other purpose is guilty of a class B misdemeanor. In addition, state agencies can request information for licensure or regulatory purposes. Prior to disclosing information, the Registry obtains the name and address of the requester, and determines that the request is for employment or regulatory purposes. To ensure you receive these notifications, it will be important for you to notify the Family Care Safety Registry when you have a change in your contact information. *Notify the Family Care Safety Registry of changes in personal or contact information using the toll-free telephone number, 866-422-6872, by email to [fcsr@health.mo.gov](mailto:fcsr@health.mo.gov), or by mail to FCSR, PO Box 570, Jefferson City, MO 65102.*

## WHAT IF I DON'T AGREE WITH THE RESULTS OF MY BACKGROUND SCREENING?

As provided in §210.912, RSMo, you have the right to appeal the information transferred to the Family Care Safety Registry. Your right to appeal is limited to the accuracy of the *transfer* of information from the state agency that maintains the background information and does not include a right to appeal the accuracy of the *substance* of the information transferred. An appeal must be filed in writing to the Office of the Director, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO, 65102, within 30 days of receiving the results of the background screening determination. An administrative appeal shall be set within 30 days of the filing of the appeal and a decision shall be made within 60 days. This right to appeal is in addition to any other appeal rights granted by state law.

## WHAT INFORMATION WILL BE DISCLOSED BY THE FAMILY CARE SAFETY REGISTRY?

Disclosure of background information on a person registered in the Family Care Safety Registry will be limited. If the person is registered, the Registry worker will disclose whether the person's name is listed in any of the background checks pursuant to §210.903, subsection 2, RSMo, and if so, which one(s). Specific information will be disclosed by the Registry pursuant to §210.921, subsection 1, subdivision (2).