



Pre-Hire Packet

- Employment Application
- Pre-Employment Statement
- Authorization to Release Medical Information
- Background Investigation Authorization
- Veteran Pre-Offer
- Voluntary Self ID of Disability
- Voluntary EOE Self ID

Please complete and email packet to Donna.Mcneil@sheppardpratt.org
If you have any questions, please call 443-462-2627.

Business/Trade School:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently enrolled			
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Tell us your work experience, listing your prior employers beginning with your present or most recent employer.

1. Employer Name:				
Address:				
City/State/Zip:				
Phone Number:				
Employment Dates:	Starting/Ending Salary:	<input type="checkbox"/> Part Time	Your Job Title:	
From: To:	\$ \$	<input type="checkbox"/> Full Time		
Supervisor's Name:			May we contact?	
Supervisor's Title:			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe Major Duties:			Reason for Leaving:	
2. Employer Name:				
Address:				
City/State/Zip:				
Phone Number:				
Employment Dates:	Starting/Ending Salary:	<input type="checkbox"/> Part Time	Your Job Title:	
From: To:	\$ \$	<input type="checkbox"/> Full Time		
Supervisor's Name:			May we contact?	
Supervisor's Title:			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe Major Duties:			Reason for Leaving:	
3. Employer Name:				
Address:				
City/State/Zip:				
Phone Number:				
Employment Dates:	Starting/Ending Salary:	<input type="checkbox"/> Part Time	Your Job Title:	
From: To:	\$ \$	<input type="checkbox"/> Full Time		
Supervisor's Name:			May we contact?	
Supervisor's Title:			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe Major Duties:			Reason for Leaving:	
4. Employer Name:				
Address:				
City/State/Zip:				
Phone Number:				
Employment Dates:	Starting/Ending Salary:	<input type="checkbox"/> Part Time	Your Job Title:	
From: To:	\$ \$	<input type="checkbox"/> Full Time		
Supervisor's Name:			May we contact?	
Supervisor's Title:			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Describe Major Duties:	Reason for Leaving:
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In your own words, please provide a brief descriptions telling why you are an ideal candidate.

Military Service Branch:	Start Date	End Date	Highest Rank Attained	Duties

Supervisory References			
Name	Company	Relationship	Phone #



Pre-Employment Statement

Please read before signing

I understand that the organization will rely, in part, on the information I provide in this Employment Application in considering whether to hire me. I understand that it is important that I provide complete and accurate information and certify that I have done so. If the organization discovers at any time that I failed to completely and honestly provide any information requested of me in this Employment Application or during the interview process, I understand that my application will no longer be considered or, if I am working for the organization, that I will be subject to disciplinary action, up to and including termination of employment.

The organization is committed to compliance with the provisions of this nation's immigration laws regarding verification of employment eligibility. Any offer of employment will be contingent upon your ability to provide legally sufficient documentation showing your eligibility to be employed by this organization. Applicants or employees that present fraudulent documents for employment verification purposes will be terminated.

I authorize the organization to contact anyone that it deems appropriate to verify the information I have provided or to further investigate my background, past performance and suitability for employment. I consent to being discussed by any person contacted by the organization and waive all rights to bring any action for defamation, invasion of privacy or any similar claim against anyone that provides information to the organization may choose to obtain background information about me from a consumer reporting agency. Before requesting a report from a consumer reporting agency, the organization will ask for my authorization. I understand that if I refuse to provide such authorization, my application for employment will not be considered.

I understand that this Employment Application is not an offer of employment. I understand that nothing contained in this Employment Application creates a contract between the organization and me for employment or any other benefit. No promises regarding employment have been made and I understand that no such promise or guarantee is binding upon the organization.

I understand that I am hired, I will be an employee "at will," meaning, I am not hired for any definite length of time and either I or the organization can terminate my employment at any time for any or no reason.

If employed, I understand and agree that the organization retains the sole right in its business judgement to modify, suspend, interpret, or cancel, in whole or in part, at any time, with or without any notice, any published or unpublished policy, practice, procedure, process, or benefit.

If employed, I understand that I may be required to comply with federal and/or state Drug Free Workplace Laws and regulations. I understand and agree to comply with such laws.

If employed, I understand that as a condition of employment that I may be required to agree to and sign the organization's confidentiality, non-complete, and/or other similar agreements. I also agree to notify the organization during the pre-employment process of any confidentiality, non-compete, and/or other similar agreement that I may have already signed with current and/or former employers.

State Specific Notices- Maryland Applicants: UNDER MARYLAND LAW, AN EMPLOYER MAY NOT REQUIRE OR DEMAND AS A CONDITION OF EMPLOYMENT, PERSPECTIVE EMPLOYMENT, OR CONTINUED EMPLOYMENT, THAT AN INDIVIDUAL SUBMIT TO OR TAKE A LIE DETECTOR OR SIMILAR TEST. AN EMPLOYER WHO VIOLATES THIS LAW IS GUILTY OF A MISDEMEANOR AND SUBJECT TO A FINE NOT EXCEEDING \$100.

Applicant's Name: _____

Applicant's Signature: _____ Date: _____



Authorization to Release Medical Information

*Please **do not** highlight any part of the form*

In order to verify my medical information, I, _____,
authorize Alliance, Inc. to obtain a description of my diagnosis and current symptoms from the licensed physician,
psychiatrist or qualified psychologist listed below:

Name (doctor, therapist, etc.): _____

Organization: _____

Address: _____

I understand this consent expires one year from the date of my signing and I may cancel my consent at any time except to the extent that action has been taken on it. To cancel my consent, I will put my request in writing to the manager of the program in which I am involved.

I have been informed of the information being released, the benefits and disadvantages (if any) I understand Alliance Inc. works through Federal and State set aside programs that require employing people with disabilities and my employment may be based on the verification of my disability. I understand my records are confidential under federal law and cannot be disclosed without my written consent, unless otherwise permitted in accordance with Federal law and regulations.

Name: _____

Date of Birth: _____

Address: _____

Individual's Signature: _____

Date: _____

Witness/Staff Signature: _____

Date: _____

Due to regulations, the provider's answers to the questions below are required on the provider's letterhead or for the doctor's office to stamp the requested area on this form.

Stamp Doctor's Signature:

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Medical Examination Report

Stamp Signature Date: _____

Patient Name:	DOB:
Address:	Phone #:
Agency Name:	Phone #:
Address:	
*Physician/Therapist Name:	Credentials:
Signature:	Date:

In order for a nonprofit agency to comply with ABILITYONE regulations, it **must verify** each individual's medical information to determine whether or not that individual **meets the program's disability requirements**.

Physical Examination Report

*(*To be completed by a medical professional physician, psychiatrist, psychologist, or nurse practitioner)*

Medical Conditions, Clinical Manifestations, and Diagnosis:

(Please state the nature and extent including applicable DSM V TR codes)

Describe Observations, Clinical Findings and Treatment Recommendations:

Patient Name:	DOB:
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*Physician/Therapist Name:	Credentials:
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Please Note: If the patient does not have any limitations, i.e. all boxes for "NONE" are checked in the functional limitations chart, they will not be eligible for hire under Alliance's disabled roster.

Functional Limitations	Degree of Limitations
Restrictions of Activities of Daily Living & Self Care	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Severe <input type="checkbox"/> None
Difficulties in Maintaining Social Functioning, Primarily with Communication	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Severe <input type="checkbox"/> None
Self-Direction: Difficulties in Maintaining Concentration, Persistence, and/or Pace	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Severe <input type="checkbox"/> None
Work Tolerance and Skills: Able to maintain job without intervention or support from the outside	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Severe <input type="checkbox"/> None

Janitorial positions may require employees to:

stand, walk use hand(s) to feel, or handle; reach with hands and arms; and stoop, kneel, crouch or crawl

Physical Capacities	Less Than 2 Hours	At Least 2 Hours	About 6 Hours
Sit			
Stand			
Walk			

Check the heaviest weight the patient can lift/carry:

Less than 10lbs 10lbs 20lbs 25lbs 50lbs 100lbs More than 100lbs

Evaluation:

Based upon your evaluation, can the patient's medical condition be expected to last, at least, 12 months?

Yes No

Is the patient's medical condition expected to result in death?

Yes No

Remarks:

Please provide any additional information clarifying how the patient's condition limits their ability to work. If possible, include a description of any restrictions in Activities of Daily Living, Communication, Self- direction, or otherwise:

Please attach records of other additional medical or mental health evidence.



Authorization of Background Investigation

I have carefully read and understand this Disclosure and Authorization form and the attached summary of rights under the Fair Reporting Act. By my signature below, I consent to preparation of background reports by a consumer reporting agency, such as HireRight, Inc. (HireRight), and to the release of such background reports to the Company and its designated representatives and agents, for the purpose of assisting the Company in making a determination as to my eligibility for employment (including independent contractor assignments, as applicable), promotion, retention or for other lawful employment purposed. I understand that if the Company hires me or contracts for my services, my consent will apply, and the Company may, as allowed by law, obtain additional background reports pertaining to me, without asking for my authorization again, throughout my employment or contract period from HireRight and/or other consumer reporting agencies.

I understand that information contained in my employment or contract application, or otherwise disclosed by me before or during my employment or contract assignment, if any, may be used for the purpose of obtaining and evaluating or contract for service.

I hereby authorize all of the following, without limitation, to disclose information about me to the consumer reporting agency and its agents: law enforcement and all other federal, state and local agencies, learning institutions (including military, and all other individuals and sources with any information about or concerning me. The information that can be disclosed to the consumer reporting agency and its agents includes, but is not limited to, information concerning my employment and earnings history, education, credit history, motor vehicle history, criminal history, military service, professional credentials and licenses.

By my signature below, I also certify the information I provided on and in connection with this form is true, accurate and complete. I agree that this form in original, faxed, photocopied or electronic (including electronically signed) form; will be valid for any background reports that may be requested by or on behalf of the Company.

Identifying Information for Consumer Reporting Agency

Printed Name: _____
(First, Middle, Last)

Other Names Used: (Alias, Maiden, Nickname) _____

of Years Names Used: _____ Date of Birth: _____ Gender: _____

Current Address: _____
(Street, PO Box, City, State, Zip, County, Date Moved There)

Former Address: _____
(Street, PO Box, City, State, Zip, County, Dates Lived There)

Social Security #: _____ Phone #: _____

Driver's License or State ID #: _____ State of Insurance: _____

Signature: _____ Date: _____

Pre-Offer Invitation to Self-Identify Protected Veterans

1. This employer is a government contractor subject to the Vietnam Era Veteran's Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA), which requires government contractors to take affirmative action to employ and advance in employment: (1) disabled veterans; (2) recently separated veterans; (3) active duty wartime or campaign badge veterans; and (4) Armed Forces service medal veterans. These classifications are defined as follows:

- A "disabled veteran" can be a veteran of the U.S. military, ground, naval, or air service who is entitled to compensation (or who, but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or a person who was discharged or released from active duty because of a service-connected disability.
- A "recently separated veteran" means any veteran during the three year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.
- An "active duty wartime or campaign badge veteran" means a veteran who served on active duty in the U.S. military, ground, naval, or, air service during a war, or in a campaign, or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.
- An "Armed Forces service medal veteran" means a veteran who, while serving on active duty in the U.S. military, ground, naval, or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

Protected veterans may have additional rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA). In particular, if you were absent from employment in order to perform services in the uniformed service, you may be entitled to be reemployed by your employer in the position you would have obtained with a reasonable certainty, if not for the absence due to service. For more information, call the U.S. department of Labor's Veterans Employment and Training Service (VETS) at 866-4-USA-DOL.

2. If you believe you belong to any of the categories of protected veterans listed above, please indicate by checking the appropriate box below. As a government contractor, subject to VEVRAA, we request this information in order to measure the effectiveness of the outreach and positive recruitment efforts we undertake pursuant to VEVRAA.

- I identify as one or more of the classifications of protected veterans listed above.
- I am not a protected veteran

3. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information provided will be used only in ways that are not inconsistent with the Vietnam Era Veteran's Readjustment Assistance Act of 1974, as amended.

4. Then information you submit will be kept confidential, except that (1) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans, and regarding necessary accommodations; (2) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment; and (3) government officials engaged in enforcing laws administered by the Office of Federal Contract Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed.

5. This employer acts pursuant to affirmative action and equal employment opportunity policies and pledges to provided equal opportunity to all persons without regard to race, sex (including pregnancy), color, age, physical or mental disability, religion, national origin, sexual orientation, gender identity, veteran's status, or any other legally protected characteristic.

Name

Date



Voluntary Confidential Self-Identification

Alliance, Inc. is subject to certain governmental record keeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, Alliance, Inc. invites candidates to voluntarily self-identify their race and ethnicity. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those which require the information be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual. This data will be kept in a confidential file, separate from the application for employment.

Name: _____

Date: _____

The following questions are optional and kept confidential.

Please check one:

Gender: Male Female Other N/A

Ethnicity: (Are you Hispanic or Latino; a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origins, regardless of race?)

Yes- Hispanic/Latino No- Other Unknown/Declined

Race: (If answered "No" above, check one of the descriptions below corresponding to the racial group which you identify.)

White, Not Hispanic/Latino
(A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Black/African American, Not Hispanic/Latino
(A person having origins in any of the Black racial groups of Africa.)

Native Hawaiian/Other Pacific Islander, Not Hispanic/Latino
(A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

Asian, Not Hispanic/Latino
(A person having origins in any of the peoples of the Far East, Southeast Asia, or the Indian subcontinent.)

American Indian/Alaskan Native, Not Hispanic/Latino
(A person having origins in any of the peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)

Two or more Races, Not Hispanic/Latino
(All persons who identify with more than one of the above five races.)

Voluntary Self-Identification of Disability

Form CC-305
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OMB Control Number 1250-0005
Expires 04/30/2026

Name: _____
Employee ID: _____
(if applicable)

Date: _____

Why are you being asked to complete this form?

We are a federal contractor or subcontractor. The law requires us to provide equal employment opportunity to qualified people with disabilities. We have a goal of having at least 7% of our workers as people with disabilities. The law says we must measure our progress towards this goal. To do this, we must ask applicants and employees if they have a disability or have ever had one. People can become disabled, so we need to ask this question at least every five years.

Completing this form is voluntary, and we hope that you will choose to do so. Your answer is confidential. No one who makes hiring decisions will see it. Your decision to complete the form and your answer will not harm you in any way. If you want to learn more about the law or this form, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

A disability is a condition that substantially limits one or more of your "major life activities." If you have or have ever had such a condition, you are a person with a disability. **Disabilities include, but are not limited to:**

- Alcohol or other substance use disorder (not currently using drugs illegally)
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, HIV/AIDS
- Blind or low vision
- Cancer (past or present)
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or serious difficulty hearing
- Diabetes
- Disfigurement, for example, disfigurement caused by burns, wounds, accidents, or congenital disorders
- Epilepsy or other seizure disorder
- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome
- Intellectual or developmental disability
- Mental health conditions, for example, depression, bipolar disorder, anxiety disorder, schizophrenia, PTSD
- Missing limbs or partially missing limbs
- Mobility impairment, benefiting from the use of a wheelchair, scooter, walker, leg brace(s) and/or other supports
- Nervous system condition, for example, migraine headaches, Parkinson's disease, multiple sclerosis (MS)
- Neurodivergence, for example, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, dyslexia, dyspraxia, other learning disabilities
- Partial or complete paralysis (any cause)
- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
- Short stature (dwarfism)
- Traumatic brain injury

Please check one of the boxes below:

- Yes, I have a disability, or have had one in the past
- No, I do not have a disability and have not had one in the past
- I do not want to answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.

For example:

Job Title: _____ Date of Hire: _____