

Other Accomplishments

Please list below any other job related accomplishments, professional distinctions, certifications, or verifiable volunteer work.

Military History

Military Status	Branch of Service	Dates of Service	
		From	To
<input type="checkbox"/> Veteran <input type="checkbox"/> Non-Veteran			
<input type="checkbox"/> National Guard <input type="checkbox"/> Reserves		<input type="checkbox"/> Inactive	
<input type="checkbox"/> Advanced ROTC		<input type="checkbox"/> Active	
Did you receive any military training related to the job for which you are applying? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:			

References

Name	Address	Occupation/Telephone Number
		Occupation: Telephone: ()

Signature

Please read carefully before signing

I certify that the answers given herein are true and complete to the best of my knowledge, and I authorize investigation of all statements contained in this application, with expectation of contacting my present employer if I have so requested on page two. I have read, understand, and agree to the above statement.

I understand that my continued employment will depend upon the successful completion of work assigned to me during a new hire period of up to ninety (90) days, and upon my continued successful performance. I have read, understand, and agree to the above statement.

While this application will be retained on file for a period of one year, as required by law, I acknowledge that this application will be considered active for a period of sixty (60) days. At that time, I must submit a new application to be considered for any employment openings. I have read, understand, and agree to the above statement.

I understand and acknowledge that, unless otherwise defined by applicable law or written agreement with Castle Country Assisted Living, Inc., any employment relationships with the Company is considered "employment at will", which means the Employee may resign at any time, and the Employer may discharge the Employee at any time, with or without cause. I have read, understand, and agree to the above statement.

If I should be employed by the Company, I understand that any false, incomplete, or misleading information given on this application or during an interview shall result in immediate discharge. I have read, understand, and agree to the above statement.

I authorize an inquiry into my background by all persons, schools, companies, corporations, credit bureaus, law enforcement agencies, protective service agencies, doctors, and other consumer reporting agencies to supply information concerning my previous employment, education, credit, driving record, etc. I have read, understand, and agree to the above statement.

I authorize the references listed above to give representatives of Castle Country Assisted Living Inc. any and all information concerning my previous or current employment and any pertinent information they may have, personal or otherwise, and release all parties from any and all liability from any damage that may result. I have read, understand, and agree to the above statement.

Signature	Date
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Castle Country Assisted Living, Inc. is an Equal Opportunity Employer. Castle Country Assisted Living, Inc. does not discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant's consideration for employment on a basis prohibited by local, state, or federal law.

Castle Country Assisted Living, Inc.
221 Cantril Street Castle Rock, Colorado 80104 (303)688-5385

Waiver and Authorization for Drug Test and Background Investigation

According to Colorado Regulations for Assisted Living Facilities (6 CCR1011-1 Chap 7):

1.104(3)(a)(iii) Alcohol or substance abuse. The facility shall not employ any person or use a volunteer who is under the influence of a controlled substance, as defined in C.R.S. Sections 18-18-203, 18-18-204, 18-18-205, 18-18-206, and 18-18-207, or who is under the influence of alcohol in the worksite. This does not apply to employees or volunteers using controlled substances under the direction of a physician, and in accordance with their health care provider's instructions.

1.104(3)(d)(i) When a background check shall be conducted. The staff who has direct personal contact with the residents of a facility and any volunteer performing personal services or protective oversight, under the auspices of the facility for residents of such a facility, shall be of good, moral, and responsible character. In making such a determination, the owner or licensee of a facility shall obtain prior to such staff or volunteer performing duties, any criminal history record information from a criminal agency subject to any restrictions imposed by such agency for any person responsible for the care and welfare or residents of such facility. If the individual is contract staff, the facility shall ensure that a background check has been conducted on such individual within 12 months prior to the date of hire by the facility. The facility shall have documentation of such background checks.

I hereby authorize a review of and full disclosure of all records concerning myself to any duly authorized agent of Castle Country Assisted Living, Inc., whether said records are of a public, private, or confidential nature. I understand that any information obtained by a drug test or personal history background investigation which is developed directly or indirectly, in whole or in part, upon this authorization will be gathered only to the extent it is relevant to the nature of said application for employment, residency, or community service, and will be considered only to determine my suitability.

Any criminal history appearing on the background investigation and any positive results of a drug test administered by a duly authorized agent of Castle Country Assisted Living, Inc., and/or a lab contracted to perform such drug tests, will be evaluated to determine if there were convictions that might jeopardize the safety of the residents.

I release Castle Country Assisted Living, Inc., its officers, agents, employees, and all persons or organizations supplying information from any and all liability, claims, demands, actions, and cause for action which I may hereafter have on account of any and all injuries and damages to me arising out of or related to the investigation of my application, drug test, or background, or incidental thereto; and for the same consideration, I promise to release and covenant not to sue the said persons, and agree to forever hold each of them harmless from any such liability, claims, demands, actions, or causes of action.

The term hereto shall be of full force and effect on the date hereof and continue until final disposition of my application, residency, or community service is rendered.

This authorization and agreement shall be binding upon me and my heirs, executors, administrators, personal representatives, assigns, and shall inure to the benefit of said officers, agents, and persons herein designated, their heirs, executors, administrators, personal representatives, assigns, and successors in office.

Applicant Signature

Date

Please legibly complete the following:

Last Name, First, Middle: _____

Date of Birth: _____

Social Security Number: _____

Written Authorization to Request a CAPS Check



COLORADO
Adult Protective Services
CAPS Check Unit

Pursuant to §26-3.1-111, C.R.S., certain employers named in the statute are required to request a check of the Colorado Adult Protective Services (APS) data system (CAPS) prior to hiring a new employee who will be providing direct care to at-risk adults. These employers are also authorized by statute, though not required, to request a CAPS check for current employees. The CAPS check will alert the employer as to whether or not a prospective or current employee has been substantiated as a perpetrator of physical abuse, sexual abuse,

caretaker neglect, and/or exploitation of an at-risk adult. More information on the CAPS check requirement can be found in Title 26, Article 3.1 of the Colorado Revised Statutes (C.R.S.) and 12 CCR 2518-01 of the Colorado Code of Regulations (CCR).

Written authorization from the applicant/employee using this form is required per APS regulations (12 CCR 2518-1). Please complete this entire form. It is recommended that you and the employer keep a copy of this form for your records.

■ EMPLOYER INFORMATION

Employer Name: _____

CAPS Check Employer ID # (XXX-#####): _____

■ REQUESTOR INFORMATION

Requestor Name: _____ Requestor Title: _____

Requestor Phone Number: _____ Requestor Phone Extension: _____

Requestor Email: _____

■ APPLICANT/EMPLOYEE INFORMATION

First Name: _____ Middle Name: _____

Last Name: _____ Date of Birth: _____

SSN (Last 4 digits): _____ Maiden Name/Previous Name(s)/Alias(es): _____

DORA License # _____

GENDER:

- Woman
- Man
- Transgender (Identifies as Woman)
- Transgender (Identifies as Man)
- Unknown

RACE/ETHNICITY (Check all that apply):

- American Indian/Alaska Native
- Asian
- Black or African American
- Hawaiian National & Pacific Islander
- Hispanic or Latino
- Middle Eastern or North African
- White

Home Phone (Including Area Code): _____

Cell/Mobile Phone (Including Area Code): _____

Work Phone (Including Area Code): _____ Work Phone Extension: _____

Home Email: _____ Work Email: _____

Current Address Street: _____

Current Address City: _____ Current State: _____

Current Zip/Postal Code: _____ Current Address Start Date: _____

All Applicants/Employees are required to have 5 years of residential history provided. If the individual listed above has less than 5 years at their current address, please list the previous addresses for the past 5 years. Use another sheet of paper, if necessary.

Previous Address (street number, street, unit, city, state, zip): _____

Address Start and End Dates: _____

Previous Address (street number, street, unit, city, state, zip): _____

Address Start and End Dates: _____

Previous Employer(s) Agency Name(s): _____

By my signature, below, I attest that all information provided in this written authorization is true and complete. My signature authorizes the employer referenced above to request a CAPS Check to determine if I have been substantiated in an APS case as a perpetrator of physical abuse, sexual abuse, caretaker neglect, and/or exploitation of an at-risk adult. I acknowledge that the information resulting from such a check will be shared directly with the employer who may use the results to inform their hiring decision. By my signature I acknowledge that this request will flag my name to allow notification to this employer of any future substantiated findings as long as I am employed by this agency.

Signature: _____

Date: _____



COLORADO
Adult Protective Services
CAPS Check Unit