



APPLICATION FOR EMPLOYMENT

Employment Application Date
 _____ / _____ / _____

PERSONAL INFORMATION:

Social Security Number **Name: Last** **First** **Middle**
 [--- ---] [] [] []

Present Address: Street **City** **State** **Zip**
 [] [] [] []

Permanent Address (if different than above): Street **City** **State** **Zip**
 [] [] [] []

Phone Number: **Fax Number:** **Cellular Number:** **Private E-mail Address:**
 [] [] [] []

State Name(s) of any Relative(s) working for AIDS Network Corporation:
 []

Please tell us how you learned about AIDS Network or who referred you:
 []

EMPLOYMENT OBJECTIVE:

Position Desired: **Date Available for Work:** **Salary Desired:**
 [] [] []

Are there any restrictions on your availability to attend work on a regular basis and/or work overtime? Yes No
 []

Have you ever applied to AIDS Network? If so, when? Were you offered employment?
 Yes No [] Yes No

EDUCATION AND TRAINING:

	Name of School	Location (City, State)	Year Completed (Circle One)	Degree & Date
High School	[]	[]	1 2 3 4	[]
College(s)	[]	[]	1 2 3 4	[]
Graduate Work	[]	[]	1 2 3 4	[]
Other School(s) (trade, etc.)	[]	[]	1 2 3 4	[]

Major Course(s) of Study: **Minor Course(s) of Study**
 [] []

FORMER EMPLOYERS:

Are you employed now? Yes No

If so, may we contact your present employer? Yes No

(PLEASE SHOW MOST RECENT EMPLOYER FIRST)

Name of Employer:

City

State

Zip

From (mo/yr)

To (mo/yr)

Beginning Monthly/Hourly Compensation

Ending Monthly/Hourly Compensation

Job Title

Immediate Supervisor

Phone #

Full Name While Employed

Job Duties

Did you voluntarily terminate your employment?:

Yes No

Reason for leaving:

Name of Employer:

City

State

Zip

From (mo/yr)

To (mo/yr)

Beginning Monthly/Hourly Compensation

Ending Monthly/Hourly Compensation

Job Title

Immediate Supervisor

Phone #

Full Name While Employed

Job Duties

Did you voluntarily terminate your employment?:

Yes No

Reason for leaving:

Name of Employer:

City

State

Zip

From (mo/yr)

To (mo/yr)

Beginning Monthly/Hourly Compensation

Ending Monthly/Hourly Compensation

From (mo/yr)

To (mo/yr)

Number of Hours Worked Per Week

Monthly/Hourly Compensation

Job Title

Immediate Supervisor

Phone #

Full Name While Employed

Job Duties

Did you voluntarily terminate your employment?:

Yes No

Reason for leaving:

SPECIALIZED SKILLS AND KNOWLEDGE:

List any achievements or activities that you consider relevant to your ability to perform the job for which you are applying, such as: awards received, memberships or offices held in professional organizations, licenses held, computer languages or software programs, foreign languages (proficiency in speaking and writing), etc.

REFERENCES:

Please provide the names of three people (not related to you) we may contact, whom you have known at least one year.

NAME	ADDRESS	RELATIONSHIP	PHONE NUMBER	YEARS ACQUAINTED
1.				
2.				
3.				

In Case of Emergency Notify:

Name

Phone Number 1 Phone Number 2

I understand and acknowledge the following:

1. I authorize investigation of all statements contained in this application and any supporting documents. I authorize AIDS Network to secure information about my experience from former employers, educational institutions, government agencies, or any references I have provided, and for those parties to provide information concerning my qualifications for employment, and I hereby release all parties from any liability arising from such investigation.
2. I understand that if I am employed, any false statement, misrepresentation, or omission of facts on this application or on any supporting documents, regardless of when discovered to be false, may result in my immediate dismissal.
3. My signature below certifies that I have read, understand, and agree to the foregoing and to the best of my knowledge and belief, the information on the application form is true and correct.

Date: _____ Signature _____

AIDS Network is an equal opportunity limited english proficiency employer.
Please contact the Executive Director of AIDS Network if you have any questions or complaints regarding this policy.

Please submit the completed application and a copy of your resume to:
AIDS Network
600 Williamson Street
Madison, WI. 53703

Fax 608-252-6559
Email hr@aidsnetwork.org



SOUTHERN WISCONSIN'S LEADING PROVIDER OF HIV/AIDS SERVICES

Self-Identification/Disclosure Form

Name: _____

Address: _____

Contact Information: _____

Desired Position: _____

AIDS Network, Inc. has filed an Affirmative Action Plan with the City of Madison in compliance with federal, state and local law. In an attempt to determine the effectiveness of our recruitment efforts, we request that you **Voluntarily** provide the following information.

Sex:

Male Female Other (Please indicate) _____

Race/Ethnicity/Cultural Identity:

- African American/Black
- Latino/Latina
- Asian/Pacific Islander
- American Indian/Native American/Alaskan Native
- White/Caucasian
- Multi-racial
- Other (Please indicate) _____

How did you find out about the position?

- Madison Times
- LaMovida
- Capitol Times or Journal
- Relative/friend/acquaintance
- Other