Culinary Job Training Program Qualifications. All Requirements Are Typical For Food Service Jobs:

1. Be at least 18 years of age.
2. Must want to find employment.
3. Be able to work without a mobility device for 7+ hours and can lift up to 50 pounds.
4. Desire to learn and improve on the skills needed to work in a food service environment.
5. Arrive on time for training, which is from 7:50 a.m. to 3:30 p.m., Monday through Friday.
6. Be willing to have your legal history checked so that you and your Employment Specialist can discuss how it may effect your job search and employment.
   a. **Note:** The presence of certain conviction(s) may determine your training location.
GENERAL INFORMATION

First: ___________________________  Middle: _______  Last: ___________________________

Preferred Pronoun (check one):  She ☐  He ☐  They ☐  Ze ☐

SSN: _____ - _____ - ______  Age: _____  DOB: ___/___/______  Gender: _______________________

Current Address: ______________________________________________________________

Street  City  State  Zip

Telephone:  Cell# ___________________________  Message # ___________________________

Preferred Contact:  Cell# ☐  OR  Message # ☐  E-mail: ___________________________

(Optional): Veteran: Yes ☐  No ☐

Do you have a Driver’s License or State ID?  Yes ☐  No ☐

Do you have a Social Security card?  Yes ☐  No ☐

Are you able to work in the United States?  Yes ☐  No ☐

REFERRAL INFORMATION

Do you currently have a friend/relative in the Work Options training program?  Yes ☐  No ☐

Have you participated in the Work Options training program before?  Yes ☐  No ☐

HOUSING

Do you currently have a safe place to live?  Yes ☐  No ☐

How many days can you stay at current location (check one)?

30 days or less ☐  30-60 days ☐  60-90 days ☐  90+ days ☐

Behind on rent/mortgage?  Yes ☐  No ☐  If yes, how much? ___________

FAMILY/CHILDREN

Marital Status:  Single ☐  Divorced ☐  Married ☐  Civil Union ☐  Widowed ☐  Other ☐

Currently providing care or shelter for any person over 18 who is unable to care for themselves?  Yes ☐  No ☐

If yes:

Elderly ☐  Person with disability ☐  Temporary ill person ☐

Currently providing care or shelter for any children under the age of 5?  Yes ☐  No ☐

Childcare in place for all children, including 5+ years of age, in your care?  Yes ☐  No ☐
LEGAL HISTORY

Have you ever been convicted of a crime          Yes [ ]        No [ ]
Are you required to register for a sex offense?  Yes [ ]        No [ ]
Do you have any upcoming court dates or unresolved legal matters? Yes [ ]        No [ ]
If yes, please explain:_______________________________

If you are currently on community supervision (probation, parole, work release), complete:

❖ Time remaining: __________________________
❖ Case Manager or PO: __________________________
❖ Phone: __________________________
❖ Email: __________________________

What are your current requirements? Please list: (classes, community service, restitution, fines)

________________________________________________________________________
________________________________________________________________________

HEALTH HISTORY

Please answer the following questions regarding your ability to complete these tasks in the food service environment.

If you have any allergies, please list: __________________________

If yes, do you have an Epipen?          Yes [ ]        No [ ]

Currently on SSI/SSDI?          Yes [ ]        No [ ]

Have you been treated for a back problem or back related injury recently? Yes [ ]        No [ ]

Do you have any surgeries or procedures scheduled? Yes [ ]        No [ ]
If “yes,” when are they scheduled? __________________________

EMPLOYMENT HISTORY

Are you currently employed?          Yes [ ]        No [ ]

Are you looking for employment?          Yes [ ]        No [ ]

Have you ever been employed in the food service industry? Yes [ ]        No [ ]

Why do you want to participate in the Work Options program? __________________________
________________________________________________________________________
When are you available to start?

ASAP [ ] 1 week [ ] 2 weeks [ ] 3 weeks [ ] 1 month

The Work Options training program requires that I can now and will be able to do all of these things safely for the duration of the training program. Please initial after reading:

_____ I am able to repeatedly lift up to 50 lbs.

_____ I am able to stand on my feet for 7 hours a day.

_____ I am able to move around and work with my hands in a fast paced environment that has hot and sharp items.

_____ I will engage in tasks that require a full range of motion, including, but not limited to, twisting, turning and reaching.

________________________________________  __________________________
Signature                                      Date
WORK OPTIONS FOR WOMEN
AUTHORIZATION FOR RELEASE OF INFORMATION FORM

I, ____________________________________________, hereby authorize Work Options to request the following information concerning myself and my dependent children on a need-to-know basis for investigatory and case management purposes. Agencies and providers who request/provide information under this release may use a copy or a facsimile of this form in place of the original signed consent form.

Please place an "x" when choosing per:

- [x] Child Welfare
- [ ] Vocational Rehabilitation
- [ ] Public Assistance/ Workforce
- [x] Employment/Payroll
- [ ] Medical and/or Mental Health
- [ ] Legal History
- [x] Substance Abuse Treatment
- [ ] Education

Other Agency:

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The information exchanged may not be used as evidence in a criminal proceeding nor be used to investigate or prosecute a suspected crime, unless such documents are subpoenaed through a court order.

I understand that any records or alcohol and drug treatment are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, Part 2 of Title 42 of the Code of Federal Regulations and that recipients of this information may share it only in connection with their official duties.

This consent automatically ends one year from the date I sign this form or when the sharing of information is no longer needed to manage or provide services to me, or when I revoke my consent, whichever occurs sooner, except to the extent that the program or person authorized to make the disclosure has already acted in reliance on this consent. I understand I may revoke this authorization at any time by signing the revocation statement below and provide this document to Work Options.

This authorization for information sharing has been explained to me. I have read it (or it was read to me) and understand its provisions. I have been given a reasonable amount of time to ask questions and consider whether to permit the sharing of information. I hereby willingly agree to share information as described above.

Date ___________________________ Signature of Client ___________________________

Date ___________________________ Signature of Work Options Staff & Title ___________________________

*** SIGN BELOW TO REVOKE RELEASE OF INFORMATION ***

I hereby revoke my authorization and consent for release of information to the parties listed on this form:

Revocation Date ___________________________ Signature of Client ___________________________
Possible Enrollment Date: __________

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