Great Beginnings

Faculty Application

Name:_____

Street Address_____

City, State, Zip_____

Phone Number:_____ Email:_____

Desired Position:_____

Date Available to Start:_____ Desired Wage:_____

Hours Availble to Work:_____

How Did you hear about this position?_____

Do you know any current or former employees of Great Beginnings? If so who?

_____

	School Name	Course of Study	Total Years Study	Degree/Diploma
Highschool				
Undergraduate College				
Graduate/ Professional				
Other				

Employment History

Employer	Start Date	End date	Essential Job Functions
Address:	Starting Salary	Ending Salary	
City, State, Zip	Supervisor Name		
Phone Number	Supervisor Email		
Reason(s) for leaving			
May we contact this employer?			

Employer	Start Date	End date	Essential Job Functions
Address:	Starting Salary	Ending Salary	
City, State, Zip	Supervisor Name		
Phone Number	Supervisor Email		
Reason(s) for leaving			
May we contact this employer?			

What value do you feel you have contributed to these companies?_____

Additional Information

Have you ever been hired with this company before? If yes, when? O yes O no

Do you have any friends or relatives employed with this company? O yes O no

Are you currently employed? O yes O no

May we contact your employer? O yes O no

Are you currently on "lay off" status and subject to recall? O yes O no

If you are under 18 years of age, can you provide proof of your eligibility to work in the United States? O yes O no

If hired, can you provide proof of your eligibility to work? O yes O no

Are you able to perform all the essential functions of the job for which you are applying with or without reasonable accommodation? O yes O no

_____

_____

If hired, are there any accommodations the company would need to provide so that you can perform all of the essential functions and duties of the job? O yes O no

_____

_____

If driving is a requirement of the position applied for, have you in the last 7 years been convicted of driving under the influence (DUI) O yes O no

If hired, do you have reliable means of transportation? O yes O no

If hired, would you be able to travel or work overtime if needed? O yes O no

Provide any additional information we should know about _____

_____

_____

_____

_____

_____

_____

_____

_____

At-Will Employment

_____ I understand and agree that if I am employed, my employment will be "at will" which means that the company may terminate the employment relationship at anytime, with or without notice. Likewise, the company will respect my right to terminate my employment at anytime, with or without cause and with or without notice. I further understand that any prior representation, expressed or implied to the contrary to the forgoing is binding on the company unless made in writing and signed by the company's president.

Testing Authorization

_____ If offered a position with the company, hereby agree to any legally permitted physical, psychological, skill, drug or medical test required by the company as a condition of employment.

Investigation Authorization

_____ I authorize investigation into all statements and references contained in this application. Said investigation may include credit, driving, criminal background, references and other background checks. By applying for this job, I also authorize post-hire investigation into my credit, driving and criminal background.

Company Obligation

_____ I understand and agree that the Company's acceptance of this job application does not mean that a position for which I am qualified is open (unless specifically posted) or that the company has agreed to hire me. I understand that the company is under no obligation to hire me as a result of accepting this completed application.

I HAVE READ AND UNDERSTOOD THE ABOVE ~~POLICY~~ STATEMENTS AND AGREE ~~TO BE~~ BOUND BY THEM IF EMPLOYED BY THE ~~COMPANY~~

_____

Signature _____ Date

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
FAMILY CARE SAFETY REGISTRY

WORKER REGISTRATION

FCSR USE ONLY

Register online at 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 ~~$14.00~~ $15 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 or call, toll free, 866-422-6872.

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

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

___ – ___ – ___

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
			☐ M ☐ 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 OUTSIDE U.S.)

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

☐ My current/potential child care, long term care or mental health care employer is:

EMPLOYER NAME

EMPLOYER ADDRESS

EMPLOYER CITY	STATE	ZIP

EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE

☐ No Employer, because I am a(n):

- ☐ Adoptive Parent
- ☐ Foster Parent/Family Member
- ☐ Home Child Care Provider
- ☐ Private Pay/Private Duty
- ☐ Student
- ☐ Volunteer
- ☐ 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	DATE OF SIGNATURE (MUST BE WITHIN SIX MONTHS OF SUBMISSION.)

Great Beginnings

Employee Benefits & Perks

- Supportive and positive work atmosphere
- Insurance, health, vision, dental and disability
- Direct deposit
- Competitive wages
- Review and raise after 6 months
- Do not rely on nap time ratios, more time with your co-teacher to plan, clean and decorate together at nap
- 10 paid vacation days per year
- 10 paid holidays per year
- Extra gross motor play in our spacious multi-purpose room
- Effective and organized program towards teacher training with Pro-solutions online classes
- A formal, tested and approved curriculum with plenty of resources, Learning Without Tears
- Large modern enclosed classrooms
- Fun events like Trunk-or Treat, Faculty Christmas party, teacher appreciation week. Earn extra money working parent night events.