

Camp Robin Rogers ♦ Camp Employment Application
 Revised January 22, 2013

2018

Print Full Name	LAST	FIRST	MIDDLE	E-MAIL ADDRESS
MAILING ADDRESS		CITY	STATE	ZIP CELL PHONE NO.
PERMANENT ADDRESS		CITY	STATE	ZIP HOME PHONE NO. OTHER PHONE NO.
ARE YOU 18 YEARS OF AGE OR OLDER?		U.S. CITIZEN?		POSITION APPLYING FOR:
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been convicted in court for other than a traffic misdemeanor? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state particulars:				

High School Name & Location	Major Area of Study	Highest Level Achieved
University Name & Location	Major Area of Study	Highest Level Achieved

From/To	Name & Address of Employer	Supervisor's Name	Pay Rate	Reason for Leaving
Job Title & Duties				
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Professional & Faculty References (list 3 persons, preferably former supervisors or faculty instructors, who can objectively assess your professional and/or scholastic performance.)			
Name	Title/Relationship	Area Code: Phone	Business Address
1.		()	
2.		()	
3.		()	

1. Have you ever been employed with The Arc? If yes, please list date of employment and position held.

2. How were you referred to The Arc?

3. If hired, with what age group would you like to work?

4. Do you have any interests, hobbies, or special skills that would benefit camp operation? (Arts, crafts, music, etc.)

5. Would you prefer weekend or weekly hours? Weekend Weekly

6. Please list any experiences in working with individuals with developmental disabilities.

7. Please list any certification(s) which you hold that may benefit camp operation. (CPR, First Aid, Lifeguard, Etc.)

8. Please list any volunteer experience.

9. What do you hope to gain through this camp experience?

I give my permission to have my photograph used in any promotional materials that The Arc may produce.

Signature

Date

The information on this application is true to the best of my knowledge.

Signature

Date



STAFF HEALTH HISTORY

Name _____

Address _____

Phone _____

Two Emergency Contacts:

Name _____ Name _____

Address _____ Address _____

Phone _____ Phone _____

Relationship _____ Relationship _____

Doctor _____ Dentist _____

Phone _____ Phone _____

Hospital preferred _____

Record of Immunizations: enter month, day, and year

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DTP					0
OPV				0	
HIB*					
MMR		0			

1. Description or any current health conditions requiring medication, treatment, or special restrictions or considerations while at camp: _____
2. Record of past medical history; diseases, hospitalizations: _____
3. List any allergies: _____
4. Date of last tetanus shot: _____

Signature of Staff Member

Date

Signature of Parent/Guardian (if Staff Member is a minor)

Date

June 2018

S M T W T F S

Please circle the dates you would be UNABLE to work during the camp season.

					1	2
3	4	5	6	7	8	9
10	11 Camp Training 9 a - 4 p	12 Camp Training 9 a - 4 p	13 Camp Training 9 a - 4 p	14 Camp Training 9 a - 4 p	15 Camp Training 9 a - 4 p	16
17	18 Camp	19 Camp	20 Camp	21 Camp	22	23
24	25 Camp	26 Camp	27 Camp	28 Camp		

July 2018

S M T W T F S

1	2 Camp	3 Camp	4 Independence Day No Camp	5 Camp	6	7
8	9 Camp	10 Camp	11 Camp	12 Camp	13	14
15	16 Camp	17 Camp	18 Camp	19 Camp	20	21
22	23	24	25	26	27	28
29	30	31				

Name (please print)

Date