

**MINNESOTA INDIAN PRIMARY
RESIDENTIAL TREATMENT CENTER, INC.**

**MASH-KA-WISEN
THUNDERBIRD-WREN**



**APPLICATION
FOR
EMPLOYMENT**

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

KIND OF WORK APPLYING FOR: _____

DO YOU PREFER: FULL TIME EMPLOYMENT () PART TIME EMPLOYMENT ()

DO YOU PREFER: DAY SHIFT () EVENING SHIFT () NIGHT SHIFT ()

NAME _____
LAST FIRST MIDDLE

ADDRESS _____
STREET CITY STATE ZIP CODE

PHONE (HOME) _____ EMAIL _____

AVAILABLE DATE FOR EMPLOYMENT _____

IF EMPLOYED, MAY WE REFER TO YOUR EMPLOYER () YES () NO

TRIBAL AFFILIATION _____

EDUCATION:

NAME OF HIGH SCHOOL _____

NUMBER OF YEARS COMPLETED _____ GED COMPLETED _____ DIPLOMA _____

COLLEGE:

NAME: _____ YEARS COMPLETED _____

ADDRESS _____ MAJOR _____ DEGREE _____

OTHER

NAME: _____ YEARS COMPLETED _____

ADDRESS _____ MAJOR _____ DEGREE _____

DESCRIBE OTHER TRAINING, EDUCATION, OR SUBJECTS OF SPECIAL STUDY OR RESEARCH INCLUDING ANY PREVIOUS EXPERIENCE IN THE FIELD OF SUBSTANCE USE DISORDER:

REFERRED BY: _____

PREVIOUS EMPLOYMENT RECORD BEGINNING WITH THE MOST RECENT POSITION

NAME & ADDRESS OF EMPLOYER	SUPERVISORS NAME & TITLE	DATES		REASON FOR LEAVING

YOUR TITLE: _____ PART TIME () FULL TIME ()

LIST JOB DUTIES BEGINNING WITH MAJOR TASKS: _____

NAME & ADDRESS OF EMPLOYER	SUPERVISORS NAME & TITLE	DATES		REASON FOR LEAVING

YOUR TITLE: _____ PART TIME () FULL TIME ()

LIST JOB DUTIES BEGINNING WITH MAJOR TASKS: _____

NAME & ADDRESS OF EMPLOYER	SUPERVISORS NAME & TITLE	DATES		REASON FOR LEAVING

YOUR TITLE: _____ PART TIME () FULL TIME ()

LIST JOB DUTIES BEGINNING WITH MAJOR TASKS: _____

MAY WE CONTACT THE EMPLOYERS PREVIOUSLY LISTED? YES () NO ()

REFERENCES: PLEASE LIST BELOW THE NAMES OF THREE PERSONS NOT RELATED TO YOU WHOM YOU HAVE KNOWN AT LEAST ONE YEAR. WE MAY CONTACT ONE OR MORE OF THESE PEOPLE IN OUR REFERENCE CHECKING PROCEDURE.

<u>NAME</u>	<u>ADDRESS & PHONE#</u>	<u>YEARS ACQUAINTED</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

IS THERE ANY OTHER INFORMATION WHICH YOU FEEL WE SHOULD HAVE IN CONSIDERING YOUR APPLICATION FOR EMPLOYMENT?

WE REQUIRE PRE-EMPLOYMENT BACKGROUND CHECKS AND DRUG SCREENS. ANY ISSUES?

YES, EXPLAIN BELOW _____

NO

ARE YOU VACCINATED AGAINST COVID OR WILLING TO BECOME SO?

YES

NO

HAVE YOU BEEN FREE FROM PROBLEMATIC SUBSTANCE USE FOR AT LEAST ONE YEAR?

YES

NO

ARE YOU OVER 18 YEARS OLD AND AUTHORIZED TO WORK IN THIS COUNTRY?

YES

NO

DO YOU HAVE A VALID DRIVERS LICENSE? (THIS IS NOT A REQUIREMENT FOR EMPLOYMENT)

YES

NO

I CERTIFY THAT ANSWERS GIVEN HEREIN ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION FOR EMPLOYMENT AS MAY BE NECESSARY IN ARRIVING AT AN EMPLOYMENT DECISION.

THIS APPLICATION FOR EMPLOYMENT SHALL BE CONSIDERED ACTIVE FOR A PERIOD OF TIME NOT TO EXCEED 45 DAYS. ANY APPLICANT WISHING TO BE CONSIDERED FOR EMPLOYMENT BEYOND THIS TIME PERIOD SHOULD INQUIRE AS TO WHETHER OR NOT APPLICATIONS ARE BEING ACCEPTED AT THAT TIME.

I HEREBY UNDERSTAND AND ACKNOWLEDGE THAT, UNLESS OTHERWISE DEFINED BY APPLICABLE LAW, ANY EMPLOYMENT RELATIONSHIP WITH THIS ORGANIZATION IS OF AN "AT WILL" NATURE, WHICH MEANS THAT THE EMPLOYEE MAY RESIGN AT ANY TIME AND THE EMPLOYER MAY DISCHARGE EMPLOYEE AT ANY TIME WITH OR WITHOUT CAUSE. IT IS FURTHER UNDERSTOOD THAT THIS "AT WILL" EMPLOYMENT RELATIONSHIP MAY NOT BE CHANGED BY ANY WRITTEN DOCUMENT OR BY CONDUCT UNLESS SUCH CHANGE IS SPECIFICALLY ACKNOWLEDGED IN WRITING BY AN AUTHORIZED EXECUTIVE OF THIS ORGANIZATION.

IN THE EVENT OF EMPLOYMENT, I UNDERSTAND THAT FALSE OR MISLEADING INFORMATION GIVEN IN MY APPLICATION OR INTERVIEW(S) MAY RESULT IN DISCHARGE. I UNDERSTAND, ALSO, THAT I AM REQUIRED TO ABIDE BY ALL RULES AND REGULATIONS OF THE EMPLOYER.

SIGNATURE OF APPLICANT

DATE

NO QUESTION ON THIS APPLICATION IS ASKED FOR THE PURPOSE OF LIMITING OR EXCLUDING ANY APPLICANT'S CONSIDERATION FOR EMPLOYMENT BECAUSE OF HIS/HER RACE, COLOR, SEX, AGE, HANDICAP, DISABILITY, OR NATIONAL ORIGIN.

PLEASE RETURN TO:

PERSONNEL DEPARTMENT
MASH-KA-WISEN TREATMENT CENTER
P.O. BOX 66
SAWYER, MINNESOTA 55780
218-879-6731
www.mashkawisen.com

CONFIDENTIAL

EEO Self-Identification Form

Notice -Completion of this form is voluntary.

We are an Affirmative Action, Equal Opportunity Employer. Our employment decisions are made without regard to race, color, religion, gender, national origin, age, disability, marital status, veteran or military status, or any other legally protected status. The purpose of this Employee *EEO Self-Identification Form* is to comply with federal government record-keeping and reporting requirements. Periodic reports are made to the government on the following information. The data you provide on this form will be kept confidential and used solely for analytical and reporting requirement purposes. This form is processed and maintained separately from your personnel file and is not used to make decisions about the terms and conditions of employment. Completion of this form is optional and voluntary. We appreciate your assistance.

1. Date Completed:
2. Name:
3. Position Applying:
4. Social Security Number: Last 4 Digits:

Voluntary Self-Identification of Ethnicity, Race and Gender

5. Race/Ethnic Code: (Please Select One)

Ethnicity:

Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race;

Race:

White (not Hispanic or Latino) – A person having origins in any of the original peoples of Europe, North Africa, or the Middle East;

Black or African American (Not Hispanic or Latino) – A person having origins in any of the Black racial groups of Africa;

Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino) – A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands;

Asian (Not Hispanic or Latino) – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam;

American Indian or Alaskan Native (Not Hispanic or Latino) – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community recognition; and

Two or More Races (Not Hispanic or Latino) – All persons who identify with more than one of the above five races.

6. Sex/Gender Code: (Please Select One)

- Male Female Non-Binary Prefer Not to Disclose

Signature:

Date:

THANKS FOR YOUR ASSISTANCE!

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 04/30/2026

Name:
Employee ID:

Date:

(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor. The law requires us to provide equal employment opportunity to qualified people with disabilities. We have a goal of having at least 7% of our workers as people with disabilities. The law says we must measure our progress towards this goal. To do this, we must ask applicants and employees if they have a disability or have ever had one. People can become disabled, so we need to ask this question at least every five years.

Completing this form is voluntary, and we hope that you will choose to do so. Your answer is confidential. No one who makes hiring decisions will see it. Your decision to complete the form and your answer will not harm you in any way. If you want to learn more about the law or this form, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

A disability is a condition that substantially limits one or more of your "major life activities." If you have or have ever had such a condition, you are a person with a disability. **Disabilities include, but are not limited to:**

- Alcohol or other substance use disorder (not currently using drugs illegally)
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, HIV/AIDS
- Blind or low vision
- Cancer (past or present)
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or serious difficulty hearing
- Diabetes
- Disfigurement, for example, disfigurement caused by burns, wounds, accidents, or congenital disorders
- Epilepsy or other seizure disorder
- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome
- Intellectual or developmental disability
- Mental health conditions, for example, depression, bipolar disorder, anxiety disorder, schizophrenia, PTSD
- Missing limbs or partially missing limbs
- Mobility impairment, benefiting from the use of a wheelchair, scooter, walker, leg brace(s) and/or other supports
- Nervous system condition, for example, migraine headaches, Parkinson's disease, multiple sclerosis (MS)
- Neurodivergence, for example, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, dyslexia, dyspraxia, other learning disabilities
- Partial or complete paralysis (any cause)
- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
- Short stature (dwarfism)
- Traumatic brain injury

Please check one of the boxes below:

- Yes, I have a disability, or have had one in the past
- No, I do not have a disability and have not had one in the past
- I do not want to answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.

For example:

Job Title:

Date of Hire: