

OXNARD CITY CORPS APPLICATION (18+)

555 SOUTH "A" STREET # 200 ■ OXNARD, CALIFORNIA 93030 ■ (805) 385-8081 ■ FAX (805) 385-8183

PERSONAL INFORMATION

DATE _____

SOCIAL SECURITY
NO.

NAME
LAST FIRST MIDDLE

ADDRESS
STREET CITY STATE ZIP CODE

PHONE NO. DATE OF BIRTH: / / MALE FEMALE
MONTH DAY YEAR

EDUCATION	NAME AND LOCATION OF SCHOOL	GRADE CURRENTLY ATTENDING	DATE GRADUATED
HIGH SCHOOL			
COLLEGE			

WORK HISTORY

(LIST BELOW ANY WORK EXPERIENCE YOU HAVE HAD, BEGINNING WITH THE MOST RECENT JOB FIRST)

DATE MONTH AND YEAR	NAME AND ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING

GENERAL INFORMATION

DO YOU HAVE A VALID CALIFORNIA DRIVER'S LICENSE? YES ___ NO ___ IF YES, DRIVER'S LICENSE# _____

LIST YOUR PERSONAL STRENGTHS: _____

LIST ANY COMPUTER OR OFFICE SKILLS: _____

LIST ANY OTHER TRAINING THAT YOU HAVE RECEIVED: _____

LIST ANY OTHER LANGUAGES YOU SPEAK AND YOUR PROFICIENCY: _____

LEGAL INFORMATION

WITHIN THE LAST PAST FOUR YEARS, HAVE YOU BEEN CONVICTED OF A CRIME INVOLVING DISHONESTY OR VIOLENCE?

YES _____ NO _____ IF YES, EXPLAIN: _____

REFERENCES: GIVE THE NAMES OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.

NAME	ADDRESS/PHONE #	BUSINESS	YEARS ACQUAINTED
1.			
2.			
3.			

I CERTIFY THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE AND CORRECT. I AGREE AND UNDERSTAND THAT ANY MISINFORMATION OR OMISSION OF INFORMATION CAN RESULT IN TERMINATION FROM OXNARD CITY CORPS.

SIGNATURE OF APPLICANT: _____ DATE: _____

OFFICE USE ONLY: OXNARD CITY CORPS COUNCIL MEMBERS ONLY

MEMBERS	COMMENTS
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

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OXNARD CITY CORPS

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Participant Emergency Information

Participant Name: _____ Participant's Birthdate: _____

Address: _____ Phone: _____

In case of emergency notify: _____
(Father/Mother/Guardian) (Phone)

In the event that I cannot be reached, please call the following friend or relative who will authorize and be responsible for the care rendered:

(Relative/Friend) (Phone)

If the above person cannot be notified, I give permission to the *City of Oxnard, Oxnard City Corps* staff or authorized representative to take any action deemed necessary in the event of an injury or illness requiring immediate medical attention. I understand that the *City of Oxnard, Oxnard City Corps* assumes no financial responsibility for medical care or ambulance transportation in the case of an emergency.

PARTICIPANT MEDICAL INFORMATION

Any health problems/allergies requiring special attention: _____

Physician: _____ Phone: _____

Address: _____

Do you have? Medicare _____ Medical _____ Private or Group Insurance _____

Insurance Company _____ Group# _____ Policy# _____

I also understand that in order to participate in *City of Oxnard, Oxnard City Corps*, I must adhere to certain dress standards. No sandals, shorts, hanging jewelry, gang affiliated attire, halter/tank tops or any clothing accessory that is not appropriate for the work being done with *Oxnard City Corps*.

I, the undersigned, give my permission to be photographed during training and authorize the use of such photos in the presentation of *Oxnard City Corps* to the press, Dept. of Labor and general public.

Participant Signature _____ Date: _____