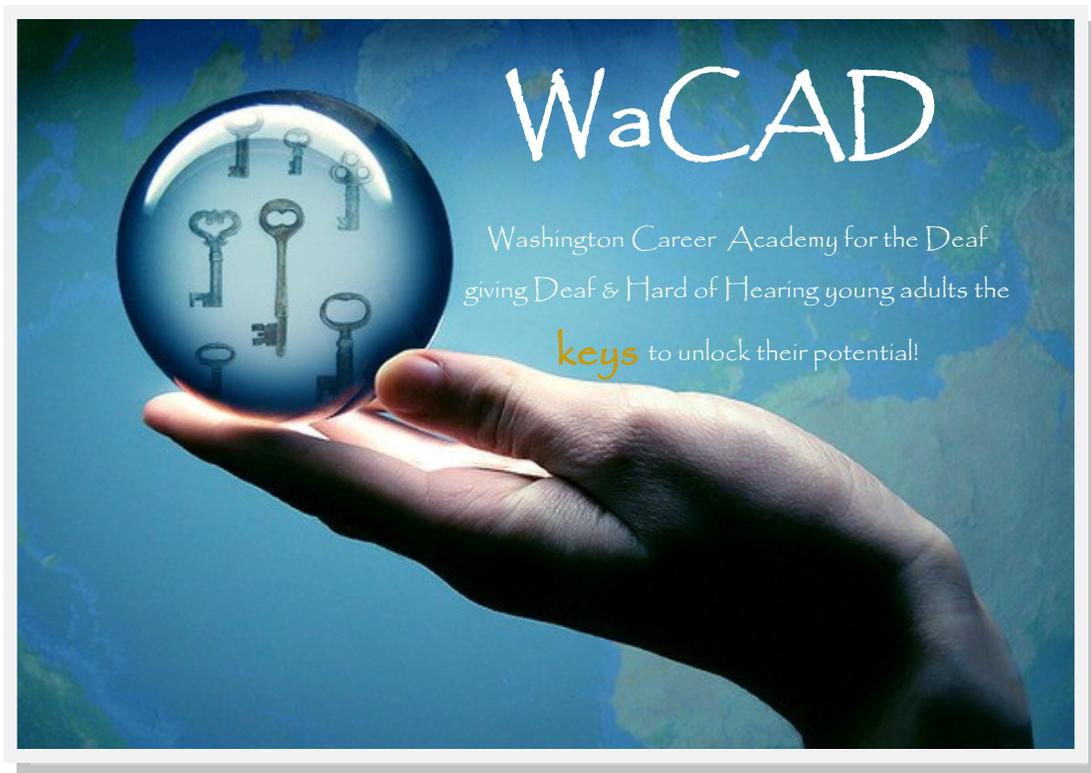


Washington Career Academy for the Deaf Application



Washington Career Academy for the Deaf (WaCAD)

Center for Childhood Deafness & Hearing Loss (CDHL)

611 Grand Blvd, Vancouver, WA 98661

(360) 696-6525 (V/TTY) / (800) 613-4228 / www.CDHL.wa.gov

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Send completed application along with a \$25 non-refundable application/processing fee
to WSD- 611 Grand Blvd, Vancouver, Wa 98661.

Refundable security deposit of \$100 due upon acceptance to program.

Admission to and termination from the
program is determined by the Washington
Career Academy for the Deaf
coordination team.

PARTICIPANT INFORMATION

PARTICIPANT INFORMATION

Are you: Deaf Hard of Hearing Deaf/Blind (Please Circle)

PARTICIPANT'S NAME LAST		FIRST	MIDDLE
ADDRESS STREET		CITY	STATE/ZIP
HOME PHONE NUMBER	TEXT PHONE NUMBER	EMAIL ADDRESS	
BIRTHDATE	AGE	GENDER	COUNTY OF RESIDENCE
EMERGENCY CONTACT	NAME	RELATIONSHIP	PHONE NUMBER

PLEASE PLACE AN 'X' NEXT TO THE AREAS YOU NEED HELP WITH

<table style="width: 100%;"> <tr><td><input type="checkbox"/></td><td>Balancing a checkbook/Budgeting Money</td></tr> <tr><td><input type="checkbox"/></td><td>Paying bills (rent, heat, water, garbage)</td></tr> <tr><td><input type="checkbox"/></td><td>Looking for a job</td></tr> <tr><td><input type="checkbox"/></td><td>Applying for a job</td></tr> <tr><td><input type="checkbox"/></td><td>Grocery shopping</td></tr> <tr><td><input type="checkbox"/></td><td>Cooking/preparing meals</td></tr> </table>	<input type="checkbox"/>	Balancing a checkbook/Budgeting Money	<input type="checkbox"/>	Paying bills (rent, heat, water, garbage)	<input type="checkbox"/>	Looking for a job	<input type="checkbox"/>	Applying for a job	<input type="checkbox"/>	Grocery shopping	<input type="checkbox"/>	Cooking/preparing meals	<table style="width: 100%;"> <tr><td><input type="checkbox"/></td><td>Using public transportation</td></tr> <tr><td><input type="checkbox"/></td><td>Buying a car</td></tr> <tr><td><input type="checkbox"/></td><td>Taxes</td></tr> <tr><td><input type="checkbox"/></td><td>Organizational skills</td></tr> <tr><td><input type="checkbox"/></td><td>Social Skills</td></tr> <tr><td><input type="checkbox"/></td><td>Self Advocacy</td></tr> </table>	<input type="checkbox"/>	Using public transportation	<input type="checkbox"/>	Buying a car	<input type="checkbox"/>	Taxes	<input type="checkbox"/>	Organizational skills	<input type="checkbox"/>	Social Skills	<input type="checkbox"/>	Self Advocacy
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Are you a U.S. Citizen?	<table style="width: 100%;"> <tr><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table>	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																				
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																						
Social Security Card	<table style="width: 100%;"> <tr><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table>	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																				
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																						
Permanent Resident Card	<table style="width: 100%;"> <tr><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table>	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																				
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																						
Green Card/Participant Visa	<table style="width: 100%;"> <tr><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table>	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																				
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																						
Are you certified in CPR/First Aid?	<table style="width: 100%;"> <tr><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table>	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																				
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																						
Do you have a food handler's card?	<table style="width: 100%;"> <tr><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table>	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																				
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																						
Do you have a DVR Counselor?	<table style="width: 100%;"> <tr><td><input type="checkbox"/></td><td>Yes</td><td><input type="checkbox"/></td><td>No</td></tr> </table>	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																				
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No																						

If yes, name of DVR Counselor and telephone number: _____

Check Program (s) you may be interested in: _____ Community College _____ Vocational/Technical _____ Work Experience

EDUCATION/Release of Information

Name _____

High School Attended _____ Fax Number _____

High School Attended _____ Fax Number _____

High School Graduate Yes No Date: _____ Please attach copy of diploma

GED Yes No Date: _____ Please attach copy of certificate

Final IEP Yes No Date: _____ Please attach copy of final IEP

PLEASE SEND REQUESTED INFORMATION TO:

Toni Stromberg—WaCAD Coordinator
Washington Career Academy for the Deaf
611 Grand Boulevard
Vancouver, WA 98661
Fax: (360) 418-4358 Office: (360) 696-6525

Release of Information:

I, _____ authorize the above listed school(s) agencies to release records listed above.
please print

All information shared will be treated in a confidential manner.

Participant Signature _____ Date _____

QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING QUESTIONS

Participant Name: _____

1. Why do you want to join the Washington Career Academy for the Deaf?

2. What are two goals you have for your future?

(1)

(2)

EMPLOYMENT HISTORY

Participant Name _____

EMPLOYMENT HISTORY	1. PRESENT OR LAST EMPLOYER		EMPLOYER'S ADDRESS
	EMPLOYER'S PHONE NUMBER	YOUR TITLE	MONTHS & YEARS EMPLOYED IN THIS POSITION FROM ____/____ TO ____/____
	TOTAL MONTHS EMPLOYED	AVERAGE HOURS/WEEK	IMMEDIATE SUPERVISOR'S NAME
	REASON FOR LEAVING		VOLUNTEER POSITION (YES/NO)
	SPECIFIC DUTIES: _____ _____ _____ _____		
WORK EXPERIENCE	1. WORK EXPERIENCE IN WHAT SCHOOL		MONTHS & YEARS EMPLOYED IN THIS POSITION FROM ____/____ TO ____/____
	AVERAGE HOURS/WEEK	TYPE OF WORK EXPERIENCE	
	EMPLOYER'S PHONE NUMBER	SUPERVISOR'S NAME	
	SPECIFIC DUTIES: _____ _____ _____ _____		
	LIST ANY OTHER NON-PAID WORK EXPERIENCE OR VOLUNTEER POSITIONS: _____ _____ _____		
	PLEASE LIST THE TYPES OF JOBS YOU ARE INTERESTED IN: _____ _____ _____ _____		

REFERENCES

List three references that are not relatives or close friends. Teachers, employers, supervisors and/or group leaders are preferred. Be sure to inform your references they may be receiving a call.

Name _____

REFERENCES	REFERENCE ONE			
	NAME	LAST	FIRST	RELATIONSHIP
	ADDRESS	STREET	CITY	STATE/ZIP
	HOME PHONE NUMBER	WORK PHONE NUMBER	CELLULAR PHONE NUMBER	
	EMAIL ADDRESS			
	REFERENCE TWO			
	NAME	LAST	FIRST	RELATIONSHIP
	ADDRESS	STREET	CITY	STATE/ZIP
	HOME PHONE NUMBER	WORK PHONE NUMBER	CELLULAR PHONE NUMBER	
	EMAIL ADDRESS			
	REFERENCE THREE			
	NAME	LAST	FIRST	RELATIONSHIP
	ADDRESS	STREET	CITY	STATE/ZIP
HOME PHONE NUMBER	WORK PHONE NUMBER	CELLULAR PHONE NUMBER		
EMAIL ADDRESS				

DISCLOSURE STATEMENT

This disclosure statement shall be completed and signed prior to acceptance into the WaCAD program

1. Have you ever been charged/adjudicated for violent offenses? If yes, what for? _____ when? _____ By which police department _____	YES _____	NO _____
2. Have you been charged/arrested/adjudicated for any sexual offenses? If yes, what for? _____ when? _____	YES _____	NO _____
3. Are you a registered sex offender? If yes, what state? _____ what county? _____	YES _____	NO _____
4. Have you ever been suspended from school? If yes, why? _____ when? _____ Where? (school name) _____	YES _____	NO _____
5. Have you ever been expelled from school? If yes, why? _____ when? _____ Where? (school name) _____	YES _____	NO _____
6. Have you in the past or are you currently receiving Mental Health services? If yes, what for? _____ Name of agency/clinic _____	YES _____	NO _____
7. Have you ever tried to harm yourself? If yes, when? _____ What was the outcome? _____	YES _____	NO _____
8. Do you have a history of drugs or alcohol abuse? If yes, what kind? _____ How often? _____	YES _____	NO _____
9. Have you ever been involved with Child Protective Services (CPS)? If yes, explain _____	YES _____	NO _____
10. Do you have any ongoing needs related to severe emotional, behavioral or mental disorder? If yes, explain _____	YES _____	NO _____
11. Do you have a psychiatric diagnosis by a psychiatrist or a provisional/suspected diagnosis by a mental health therapist? If yes, explain _____	YES _____	NO _____
12. Do you need any special accommodations? If yes, explain _____	YES _____	NO _____

I authorize the Washington Career Academy for the Deaf to conduct a background check on me. I certify under penalty of perjury, under the laws of the State of Washington that the above information is true and correct.

 Date of Birth Social Security Number

 Maiden Name of other aliases used

 Print Full Name

 Signature

 Date

 Place signed (city/state)

WASHINGTON CAREER ACADEMY FOR THE DEAF

Participant Health Record/Emergency Information

PARTICIPANT NAME: _____ SEX: _____ DOB: _____

Medical Emergency Permission	Yes	No	Restrictions
Local physicians and physicians contracted by CDHL may provide			
My physician may be contacted as needed.			
I give permission for CDHL staff to act on my behalf when making			
Nurses may convey medical information if needed that will be kept confidential, as they perceive beneficial, to staff working with participants.			

Medical History	
Health Conditions that are Life Threatening: Any condition that is life threatening, according to RCW 28A.210 Sec. I) requires that a emergency care plan be in place before the participant attends WaCAD.	Please note any health condition that are life threatening: (asthma, seizures, diabetes, allergies, etc.)
Please list all chronic and acute medical conditions or concerns.	
Please list allergies to medication, food, or insect sting:	
Special Diet:	Reason:
Activity Restriction:	Reason:
Medical Emergency Contacts:	
Insurance Information	
Name & Address of Insurance Company	Policy & Group Numbers/Union & Local

I am responsible for providing payment or medical insurance coverage for myself including medical expenses, evacuation and/or emergency transportation charges. Washington Career Academy for the Deaf does not provide medical insurance coverage and will not be held responsible for medical expenses under any circumstance.

Participant Signature _____ Date: _____