

## Sunflower Bakery and Hospitality Employment Training Application 2023-2024

Please provide all information requested, indicating NA where not applicable.

Please let us know if you need an accommodation to complete this application.

### APPLICANT INFORMATION

Name: \_\_\_\_\_ Nickname \_\_\_\_\_ Gender: M \_\_ F \_\_ NB \_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Phone: Day \_\_\_\_\_ Evening \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Living Arrangements: (Check one)

With family \_\_\_\_\_ Spouse \_\_\_\_\_ Other \_\_\_\_\_ Alone \_\_\_\_\_

Legal Guardian(s): \_\_\_\_\_ Guardian's Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Sunflower only accepts students who are planning to seek employment after training. Do you have permission to work in the United States?** \_\_\_\_\_ If accepted for training, then documentation must be presented at that time. To review acceptable documentation, please go to <http://www.uscis.gov/files/form/i-9.pdf>, scroll to the 5th page and read, "Lists of Acceptable Documents," to ensure you have the correct ones.

**I understand that it is Sunflower Bakery's policy that ALL APPLICANTS MUST BE FULLY VACCINATED FOR COVID-19, or be exempt for religious or medical reasons, in which case they must show proof of a negative COVID test within 48 hours of interviewing, participating in Assessments, or beginning a class.** \_\_\_\_\_ (Please initial here.)

**EDUCATION** Please list education in chronological order, including high school attended, post-secondary school or college and all dates. Indicate if you graduated with a certificate/diploma/degree and the date.

Name of school \_\_\_\_\_ Dates \_\_\_\_\_ Certificate/diploma/degree? \_\_\_\_\_

**TRAINING & EMPLOYMENT** Please list training programs and employment in chronological order. Use back of page if necessary. **Attach resume if you have one.**

Name of employer or training program	Dates	Contact Name	Contact Number
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**BAKING EXPERIENCE** Have you had any experience cooking or baking, either on a job or at home? Yes \_\_ No \_\_ Have you had any experience working in customer service, food service, or a retail environment? \_\_ Yes \_\_ No \_\_ Do you have a genuine interest in training for a job in the food or hospitality industry? Yes \_\_ No \_\_

If **yes** to above, please do a little self-assessment of what you have tried from the list below. Please rate for each skill:

Can do independently = I      Need help = NH      Not successful even with help = NS

Identify ingredients \_\_\_\_\_

Identify utensils \_\_\_\_\_

Wash dishes \_\_\_\_\_

Clean tables \_\_\_\_\_

Mop floors \_\_\_\_\_

Sweep floors \_\_\_\_\_

Measure with measuring cups \_\_\_\_\_

Use measuring spoons \_\_\_\_\_

Use sharp knives \_\_\_\_\_

Understand need to wash hands \_\_\_\_\_

Use whisk \_\_\_\_\_

Use rubber spatula \_\_\_\_\_

Can lift and carry 50 pounds \_\_\_\_\_

Turn oven off/on \_\_\_\_\_

Use microwave \_\_\_\_\_

Use electric hand mixer \_\_\_\_\_

Use food processor \_\_\_\_\_

Use rubber gloves \_\_\_\_\_

Use electric stand mixer \_\_\_\_\_

Tie/secure apron \_\_\_\_\_

Remove hot pans from oven \_\_\_\_\_

Make coffee or tea \_\_\_\_\_

Take customer orders \_\_\_\_\_

Bag or box purchases \_\_\_\_\_

Wrap food in plastic wrap \_\_\_\_\_

Restock products \_\_\_\_\_

Empty trash in dumpster \_\_\_\_\_

Use cash register/other point of sales equipment \_\_\_\_\_ Answer questions about products \_\_\_\_\_ Count change in bills and coins \_\_\_\_\_

Name of Applicant \_\_\_\_\_

Please indicate if you are able to do the following things, with or without reasonable accommodation:

Read at or about the 4<sup>th</sup> grade level \_\_\_Yes \_\_\_No      Calculate basic math at 4<sup>th</sup> grade level \_\_\_Yes \_\_\_No

Stand for 4 hours while working    \_\_\_Yes \_\_\_No

Answering the following question is voluntary. If you decline to do so, it will not affect consideration for the program.

Our mission is to prepare adults 18 and over with learning differences, who would benefit from skilled training for employment in baking, hospitality, or other related industries. Do you have learning differences? \_\_\_Yes \_\_\_No

**Additional Information**

Please check appropriate spaces that apply to you:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Learning Disability                    | <input type="checkbox"/> Behavior problems                        | <input type="checkbox"/> Limited mobility          |
| <input type="checkbox"/> Autism spectrum disorder               | <input type="checkbox"/> Speech/language impairment               | <input type="checkbox"/> Depression                |
| <input type="checkbox"/> Mild intellectual disability           | <input type="checkbox"/> Anxiety disorder                         | <input type="checkbox"/> Cerebral palsy            |
| <input type="checkbox"/> Moderate intellectual disability       | <input type="checkbox"/> Attention deficit hyperactivity disorder | <input type="checkbox"/> OCD                       |
| <input type="checkbox"/> Epilepsy/seizure disorder              | <input type="checkbox"/> Hearing loss                             | <input type="checkbox"/> Limited vision            |
| <input type="checkbox"/> Psychiatric diagnosis/ mental illness* | <input type="checkbox"/> TBI                                      | <input type="checkbox"/> Chronic medical condition |

Are you currently taking any medications for any of the above? \_\_\_yes\_\_\_no

If yes, which medications? \_\_\_\_\_  
\_\_\_\_\_

**\*Psychiatric Diagnosis**

Primary Diagnosis \_\_\_\_\_

Additional Diagnoses \_\_\_\_\_

Please attach a copy of the most recent psychological evaluation results or IEP.

Please comment on any of the above with regard to educational, training or work settings. Please indicate any restrictions from participation in Bakery activities. Use back of page if necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BEHAVIORAL CONCERNS**

Do you (check if yes):

- |  |  |
|--|--|
| Threaten to do physical violence _____       | Ignore or resist following instruction or routines _____ |
| Damage personal property _____               | Lie or steal _____                                       |
| Damage the property of others _____          | Abuse self _____   |
| Damage public property _____                 | Abuse substances _____                                   |
| Use angry language _____                     | Have socially unacceptable sexual habits _____           |
| Have violent temper or temper tantrums _____ | Exhibit offensive behavior with peers _____              |
| Have difficulty with authority figures _____ | Have a record of any arrests _____                       |

Please comment on any of above with regard to educational, training or work settings:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Sunflower Bakery has a zero tolerance policy for violence, threats of violence, damage to property, stealing, substance abuse, etc. A criminal background check may be required.**

Name of Applicant \_\_\_\_\_

**Sunflower Bakery - Other Releases**

I hereby give permission to the professionals listed below to release information that would relate to my training/employment with the Sunflower Bakery. This would include diagnoses, treatment summaries, test results, behavior management programs, verbal exchanges between treating persons or facilities, and any other information or recommendations considered pertinent to this relationship.

\_\_\_\_\_ Date: \_\_\_\_\_ (today) through \_\_\_\_\_ (18 mos. from application date)

Relationship to applicant \_\_\_\_\_

Signature of applicant/custodial parent/guardian: \_\_\_\_\_

**REFERENCES**

Please provide information below for at least **one professional contact** from any previous employment or vocational training/day/school programs, who may be used as a reference. Please provide a copy of most recent IEP from high school if you have one. Please provide information below for **one contact person from any current or previous DDA or DORS service provider** who may be used as a reference. Please list any **therapists** with whom the applicant may be currently involved.

Name/ Title/ Agency/ Address/ Phone/ E-mail

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any additional information you would like to share?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HOW DID YOU FIND OUT ABOUT SUNFLOWER BAKERY? \_\_\_\_\_

HAVE YOU MET WITH ANYONE FROM THE MD DIVISION OF REHABILITATION SERVICES (DORS)? \_\_\_\_ YES \_\_\_ NO

IF IN VIRGINIA, Department of Aging and Rehabilitative Services? \_\_\_\_ YES \_\_\_\_ NO

IF IN DC, Rehabilitation Services Administration? \_\_\_\_ YES \_\_\_\_ NO

DO YOU HAVE A DORS OR OTHER COUNSELOR FROM ONE OF THE ABOVE REHABILITATION SERVICES? \_\_\_\_ YES \_\_\_\_ NO  
IF SO, WHO AND AT WHICH OFFICE?

\_\_\_\_\_

**HEALTH AND MEDICAL INFORMATION**

Name of Applicant \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Telephone number: \_\_\_\_\_ FAX: \_\_\_\_\_

Name of Psychiatrist/Therapist/Counselor (if applicable): \_\_\_\_\_

Telephone number \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

Name of Dentist: \_\_\_\_\_ Telephone number: \_\_\_\_\_

Medical insurance covered by (name of company) \_\_\_\_\_

Group: \_\_\_\_\_ Governmental Program: \_\_\_\_\_

Policy number: \_\_\_\_\_ Medical concerns \_\_\_\_\_

**EMERGENCY CONTACTS**

Emergency contact #1 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Day phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ e-mail \_\_\_\_\_

Emergency contact #2 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Day phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ e-mail \_\_\_\_\_

Emergency contact #3 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Day phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ e-mail \_\_\_\_\_

**Medical Release**

I/ the applicant have/s permission to participate in all Sunflower Bakery activities except as noted by me. I give permission to the physician selected by Sunflower Bakery to order x-rays, routine tests, and treatment related to my health/the health of the participant for emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for me/this applicant. I understand the information on this form will be shared on a "need to know" basis with Bakery staff. I give permission to photocopy this form. In addition, the Sunflower Bakery has permission to obtain a copy of the applicant's health record from providers who treat him/her and these providers may talk with the Bakery's staff about the applicant's health status.

\_\_\_\_\_ Date: \_\_\_\_\_ through \_\_\_\_\_ Relationship to applicant \_\_\_\_\_

Signature of applicant/cust. parent/guardian      today      (18 months from application date)

**ADDITIONAL PROGRAM REQUIREMENTS**

**SUPPORT PERSON**

Each applicant must have a support person/agency whether a family member, friend, social worker, service provider or other person/entity who will be available to provide support throughout the training and employment. Please provide name(s) and relationship.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name of Applicant \_\_\_\_\_

How would you see this person involved? (please check all that apply)

\_\_\_ Attend a meeting with you before you would begin the program to discuss the program and expectations.

\_\_\_ Someone to help you resolve concerns, problems, barriers that may be preventing your full participation.

\_\_\_ Receive copies of evaluations.

\_\_\_ Be available to you to help review material or practice skills being learned.

\_\_\_ Person will sign Support Agreement upon applicant's acceptance for training.

Name of Applicant \_\_\_\_\_

**Next steps:** after we review your application, we will contact you regarding an interview. The interview includes a meeting to share and gather information. You will be expected to provide information about your education, your work and training experiences and your interest in baking and/or hospitality. You will complete a brief basic math quiz and you may spend some time in the kitchen with a chef, as well. You may also be asked to return to do a 3-day hands-on Kitchen Assessment or a 2-day Hospitality Assessment.

**Fees: Sunflower Bakery works with all appropriate candidates to ensure their ability to participate in our program.**

The cost of the program is satisfied through Maryland's Division of Rehabilitation Services (DORS), RSA in DC and/or private pay. Private pay includes individual/family participation and/or generous needs-based funding available through Sunflower Bakery. You may also be eligible for funding through a service provider or another agency. Program costs include a \$500 Kitchen Assessment Fee or \$250 Hospitality Assessment Fee, plus a fee for supplies and equipment, as well as the costs of instruction and job search guidance during the 26-week program. Hospitality students may be paid, if they qualify, during the 8-week internship.

PLEASE RETURN THIS APPLICATION TO:

SUNFLOWER BAKERY

ATTENTION: PROGRAMS

5951 Halpine Road, Rockville, MD 20851

OR E-MAIL to

[programs@sunflowerbakery.org](mailto:programs@sunflowerbakery.org)

Thank you for completing this application.