

Sunflower Bakery and Hospitality Employment Training Application 2025-2026

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 _____ Age _____

Select one of the following categories: Asian Black or African American Hispanic or Latino White
 Native American or Alaska Native Native Hawaiian or Other Pacific Islander Prefer not to say

Living Arrangements (Check one): With family _____ Spouse _____ Alone _____ Other _____

Legal Guardian(s): _____ Guardian's Home phone _____

Work phone _____ Cell _____ E-mail _____

Please select which program you are interested in: Pastry Arts Hospitality Culinary

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.

EDUCATION

High School _____ Dates _____ Certificate/diploma _____

College _____ Dates _____ Certificate/degree _____

Training Program _____ Dates _____

Program Contact Name _____ Phone Number _____

VOLUNTEER EXPERIENCE & EMPLOYMENT

Please list volunteer experiences and employment in chronological order. Use back of page if necessary. **Attach resume if you have one.**

Name of volunteer supervisor or employer _____ Dates _____ Contact Name _____ Contact Number _____

KITCHEN AND HOSPITALITY 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:
(continued on next page)

Name of Applicant _____

Can do independently = I Need help = NH Not successful even with help = NS Never Attempted = NA

Identify ingredients _____

Identify utensils _____

Sweep floors _____

Clean tables _____

Mop floors _____

Use sharp knives _____

Measure with measuring cups _____

Use measuring spoons _____

Use rubber spatula _____

Can lift and carry 35 pounds _____

Use whisk _____

Use microwave _____

Use electric hand mixer _____

Turn oven off/on _____

Put on rubber gloves _____

Use electric stand mixer _____

Use food processor _____

Remove hot pans from oven _____

Make coffee or tea _____

Read a food service thermometer _____

Bag or box purchases _____

Wrap food in plastic wrap _____

Tie/secure apron _____

Empty trash into dumpster _____

Use cash register/other point of sales equipment _____

Communicate with customers _____

Count change in bills and coins _____

Set oven to designated temperature _____

Restock products _____

Take direction _____

Set a timer _____

Answer questions about products _____

Ask for help _____

Use a scale _____

Follow a recipe _____

Wash Dishes _____

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

Read at or about the 4th grade level? Yes ___ No ___

Calculate basic math at 4th 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:

Anxiety disorder

Hearing loss

OCD

Attention deficit hyperactivity disorder

Learning Disability

Psychiatric diagnosis/mental illness*

Autism spectrum disorder

Limited mobility

Speech/language impairment

Cerebral palsy

Limited vision

TBI

Chronic medical condition

Mild intellectual disability

Dyslexia

Depression

Down Syndrome

Epilepsy/seizure disorder

Moderate intellectual disability

Are you currently taking any medications for any of the above? Yes ___ No ___

If yes, which medications? _____

Primary Diagnosis _____

Additional Diagnosis _____

*Psychiatric Diagnosis _____

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

Name of Applicant _____

BEHAVIORAL CONCERNS

Do you (check if yes):

Damage personal property_____

Threaten to self-harm_____

Damage the property of others_____

Self-harm_____

Use angry language_____

Threaten to harm others_____

Have violent temper or outbursts_____

Harm others_____

Have difficulty with authority figures_____

Abuse substances_____

Bully others_____

Have socially unacceptable sexual habits_____

Ignore or resist following instruction or routines_____

Exhibit offensive behavior with peers_____

Lie_____

Have a record of any arrests_____

Steal_____

A criminal background check may be required.

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

Sunflower Bakery provides a safe environment. I agree that while I am at Sunflower Bakery, I will not engage in violence, threats of violence, threats of harm to self or others, damage to property, stealing, substance abuse, bullying, etc.

Signature of Applicant: _____

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.

Name of Therapist(s): _____

Name of Psychiatrist: _____

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

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 or most recent psychological report if you have one.** Please provide information below for one contact person from any current or previous DDA, DORS or RSA service provider who may be used as a reference.

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

Name of Applicant _____

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 DC, THE REHABILITATION SERVICES ADMINISTRATION (RSA)? ____ YES ____ NO

IF IN VIRGINIA, THE DEPARTMENT OF AGING AND REHABILITATIVE SERVICES (DARS)? ____ YES ____ NO

ARE YOU APPROVED BY:

THE DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)? ____ YES ____ NO

Self-Directed? ____ YES ____ NO

DO YOU HAVE A COUNSELOR/CASE MANAGER FROM ONE OF THE ABOVE REHABILITATION SERVICES? ____ YES ____ NO

IF SO, WHO AND AT WHICH OFFICE?

HEALTH & MEDICAL INFORMATION

Primary Physician: _____ Telephone number: _____ FAX: _____

Name of Psychiatrist/Therapist/Counselor (if applicable): _____

Telephone number: _____

Name of Neurologist (if applicable): _____ Telephone number: _____

ALLERGIES: _____

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: _____

Name of Applicant _____

MEDICAL RELEASE

I/The applicant have/has 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.

Name: _____ Date: _____ (today) through _____ (18 mos. from application date)

Relationship to applicant: _____

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.

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.

Acceptance Policy

Acceptance into our program requires an interview and assessment specific to the program you are wanting to enroll in. Results from the interview and assessment will be reviewed by the acceptance committee, and a final decision will be made by the Director of Student Services and Program Director. The final decision will be communicated to the prospective student within 2 weeks of the assessment.

PLEASE RETURN THIS APPLICATION TO:

**SUNFLOWER BAKERY
ATTENTION: PROGRAMS
5951 Halpine Road, Rockville, MD 20851**

OR E-MAIL to programs@sunflowerbakery.org

Thank you for completing this application.