

APPLICATION FOR  
**ADMINISTRATIVE EMPLOYMENT**

CLAIBORNE COUNTY BOARD OF EDUCATION  
1403 TAZEWELL ROAD  
P.O. BOX 179  
TAZEWELL, TENNESSEE 37879  
Telephone: 423-626-3543  
Fax: 423-626-5945

Name: \_\_\_\_\_  
                                Last                                First                                Middle                                Maiden

Address: \_\_\_\_\_  
                                Street  City                                ST                                ZIP

Phone # (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

Social Security # XXX-XX-\_\_\_\_ Date Available for Employment: \_\_\_\_\_

Applying For (Position): \_\_\_\_\_

**INFORMATION FOR FILING APPLICATION**

1. Complete and return application to the Director of Schools' Office. Include with application pertinent documents such as:
  - a. Copy of Tennessee teacher license
  - b. College transcript(s)
  - c. Resume
  - d. Photograph
  - e. Physician's Certificate (Verification of Physical Exam)

**PERSONAL DATA**

List type(s) of Teacher License(s) held:

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

Area(s) of Certification and/or Endorsement:

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

**PLEASE COMPLETE THE BACK OF THIS APPLICATION**

\*\*\*APPLICATIONS REMAIN ON FILE FOR TWO YEARS\*\*\*

**Mission: Equal Access to and Promotion of Educational Excellence**

Claiborne County Schools do not discriminate on the basis of race, sex, color, religion, age, veteran status or disability in provision of education programs and services or employment opportunities and benefits in pursuant to the requirements of Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and other state and federal laws.

**EDUCATION**

Include high school, college, and graduate work in order taken:

<u>School</u>	<u>Date of Attendance</u>	<u>Semester Hrs.</u>	<u>Major</u>	<u>Degree</u>

**EXPERIENCE**

<u>Name of School</u>	<u>Location</u>	<u>Dates</u>	<u>Number Years</u>	<u>Position</u>

**PROFESSIONAL REFERENCES**

<u>Name</u>	<u>Address &amp; Phone</u>	<u>Position</u>

**APPLICANT STATEMENT**

I certify that all statements made in this application are true and complete, and that any intentional misstatements of material facts will subject me to disqualification or dismissal. In submitting this application for employment, I authorize an investigation of all statements contained herein.

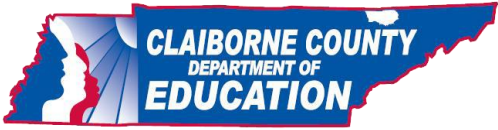
I further certify that I (\_\_\_\_ have \_\_\_\_ have not) been dismissed from any previous employment for improper or unprofessional conduct, inefficient service, neglect of duty, incompetence, or insubordination as defined in Tennessee Code Annotated Section 49-5-501. (If "have" is indicated, explain fully the details of each instance of conduct on a separate sheet of paper. The employer's non-renewal of a yearly contract need not be indicated unless the non-renewal was based on one of the factors listed above.)

I understand that any intentional misrepresentation of any of these certifications may subject me to the penalties prescribed in Tennessee Code Annotated Section 49-5-406.

Legal Name (printed): \_\_\_\_\_

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

---FOR OFFICE USE ONLY---			
Required Documents	<b>YES</b>	<b>NO</b>	References Checked By _____
Background Check Clear	<b>YES</b>	<b>NO</b>	Date of Background Clearance _____
Interview Date _____			Interviewed By _____
Date of Physical Exam _____			
Hire Date _____			Position _____
School _____			



**PHYSICIAN'S CERTIFICATE  
FOR CLAIBORNE COUNTY BOARD OF EDUCATION EMPLOYEE**

I, \_\_\_\_\_, *hereby certify that I am a*  
(Physician's Name)

*licensed physician in* \_\_\_\_\_ *County, State of Tennessee, and that*  
(County)

*on* \_\_\_\_\_ *I examined* \_\_\_\_\_  
(Date) (Claiborne County Board of Education Employee)

*and found him/her to be free of any physical ailment, disease, or defect that would disqualify  
him/her as an employee of the Claiborne County School System.*

\_\_\_\_\_  
(Signature of Examining Physician)

Printed or stamped name of physician and office address:

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

**NOTE: A tuberculosis x-ray, skin test, or evaluation (screening) is required.**

Test Result: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Health Professional)

\_\_\_\_\_  
(Date)