

APPLICATION FOR
PROFESSIONAL EMPLOYMENT

CLAIBORNE COUNTY BOARD OF EDUCATION

1403 TAZEWELL ROAD

P.O. BOX 179

TAZEWELL, TENNESSEE 37879

Telephone: 423-626-3543

Fax: 423-626-5945

Mission: Equal Access to and Promotion of Educational Excellence

(Applications remain on file for two years.)

Legal Name: _____
Last First Middle Maiden

Present Address: _____
Street City ST ZIP

Permanent Address: _____
Street City ST ZIP

Phone # (Home): _____ (Work): _____ (Cell): _____

Social Security #XXX-XX-_____ Driver's License #: _____

Applying For (Position): _____ Grade Level Preferred: (1st choice) _____ (2nd choice) _____

Date Available for Employment: _____

INFORMATION NEEDED WHEN 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 or verification that licensure is pending
 - b. College transcript(s)
 - c. Copy of Praxis scores
 - d. Resume
 - e. Photograph
 - f. Physician's Certificate (Verification of physical exam)

PERSONAL DATA

REQUIREMENT: YOU MUST POSSESS A STATE OF TENNESSEE TEACHER'S CERTIFICATE

License Number: _____

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

Area(s) of Certification and/or Endorsement:

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>

WORK 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 & Phone</u>	<u>Position</u>

APPLICANT STATEMENT

I recognize that, if I am employed, the Claiborne County Board of Education will assign or reassign me to a specific position as the need requires.

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.

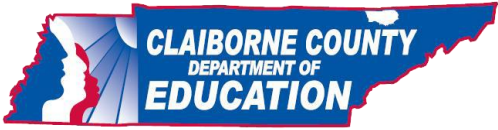
I further certify that I (____ have ____ have not) been dismissed from any previous employment for improper or unprofessional conduct, inefficient service, neglect of duty, incompetence, or insubordination as defined in Tennessee Code Annotated Section 49-5-501. (If "have" is indicated, explain fully 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	YES	NO	References Checked By _____
Background Check Clear	YES	NO	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)