



Date: \_\_\_\_\_

**CONTACT INFORMATION**

Applicant First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Age: \_\_\_\_\_ School (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Name of Guardian(s) if applicable: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency contact person (if different from above): \_\_\_\_\_

Emergency Phone: \_\_\_\_\_

**SKILL BUILDING EXPERIENCE**

Do you have any experience in the following areas?

Typing Yes \_\_\_\_\_ No \_\_\_\_\_ Shredding paper Yes \_\_\_\_\_ No \_\_\_\_\_

Cleaning tables Yes \_\_\_\_\_ No \_\_\_\_\_ Cleaning Microwaves Yes \_\_\_\_\_ No \_\_\_\_\_

Pushing Grocery Carts Yes \_\_\_\_\_ No \_\_\_\_\_ Putting Away Groceries Yes \_\_\_\_\_ No \_\_\_\_\_

Laundry Yes \_\_\_\_\_ No \_\_\_\_\_ Helping Others Yes \_\_\_\_\_ No \_\_\_\_\_

Can you tell time? \_\_\_\_\_

Do you follow a daily schedule? \_\_\_\_\_

**WORK EXPERIENCE**

Please tell us about any work experience you may have. Please include:

- 1) Where you worked
- 2) Your job title
- 3) How long you worked there

\_\_\_\_\_

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Are you currently working?  Yes  No If, "yes" how many hours per week? \_\_\_\_\_

Name of employer: \_\_\_\_\_ Job Title: \_\_\_\_\_

**PERTINENT INFORMATION**

Education

Highest level of education completed (circle): 6 or fewer years 7 8 9 10 11 12 higher

Degree(s) if applicable:

Can you read?  Yes  No Grade Level: \_\_\_\_\_

Math Skills:  Very basic (addition/subtraction)  Higher level

Are you able to take direction?  Yes  No

Are you able to follow direction?  Yes  No

Are you able to speak?  Yes  No

Are you able to hear?  Yes  No

Do you have any physical limitations that would limit your participation?  Yes  No

If yes, please describe \_\_\_\_\_

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Specific accommodations needed

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How will you get to class every day?

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What do you hope to accomplish by completing the training? \_\_\_\_\_

**PERSONAL INFORMATION**

What is your disability? \_\_\_\_\_

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Do you have seizures?  Yes  No

Do you take medication?  Yes  No

If yes, please list all medications: \_\_\_\_\_

Do you have any behavior problems?  Yes  No

Are you your own guardian?  Yes  No

### POLICY & PAYMENT

Session:	Fee:	# of Registrants:	Cost:
Culinary Class	\$100 x	_____	_____
			= _____

**Make a donation?** Your tax-deductible donation will help us to further our mission of enriching the lives of people with disabilities.

+ \_\_\_\_\_

**TOTAL =** \_\_\_\_\_

**\*Payment is due on first night of class- please do not send payment with form.\***

We accept cash or check made payable to EPIC.

#### Registration and Cancellation Policies

- **REGISTRATION DEADLINE: MONDAY, JANUARY 15.** Please mail or drop-off form to the address below.  
EPIC  
Attn. Kelly Stewart  
1913 W. Townline Rd.  
Peoria, IL 61615
- This form must be completed in its entirety in order for student to be registered.
- Please notify us of any cancellations at least one week in advance.
- No refunds will be given after class has begun.
- Student will be dropped from the class if payment is not received by the first session.
- EPIC reserves the right to drop a student from the class at any time due to behavioral or other issues that affect our ability to effectively serve the student and/or class.

We consider all applicants without regard to race, color, religion, gender, ancestry, marital status, veteran status, national origin, sexual orientation, age or disability and any other legally protected status.

Thank you for completing this form and for your interest in training for employment for autism.

#### AGREEMENT AND SIGNATURE

Name (printed)	
Signature	
Date	

