

# The Teaching Kitchen

## Application Process and Materials

### 1 Submit all application materials

- Application Form**  
Please complete carefully and include professional references
- Employment Eligibility Verification (2 Forms)**  
Acceptable forms: US Birth Certificate, Passport, Naturalization Certificate, Green (Alien Resident) Card, Work Permit, Driver's License/ID, Social Security Card
- Proof of Residency**  
Acceptable forms: Driver's License with current address or a utility bill with current address
- Proof of Family Income and Size**  
Most recent paystubs, DTA letter, 1040 form, or Unemployment Insurance (U.I.) statement (If you receive more than one please submit copies of each one.)

### 2 Adult Basic Education Assessment

This reading and math assessment is scheduled approximately once a month. You will be assigned a date and time to take the assessment after you have completed step one.

### 3 Interview

Qualified applicants will receive interviews after completing the application and assessment. Applicants may be requested to return for a second interview.

### 4 Notification of acceptance

All applicants will be notified by mail within a reasonable time period if they have or have not been accepted into the Teaching Kitchen. Failure to complete all the above steps will prevent you from being considered for the Teaching Kitchen program.

Please contact Danielle with any questions at  
617.522.7777 or [dreilly@servings.org](mailto:dreilly@servings.org)



# COMMUNITY SERVINGS

DELIVERING MEALS, DELIVERING HOPE

## Food Service Training Program Application

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/20\_\_\_\_  
*Last First Middle Initial*

Mailing Address \_\_\_\_\_  
*Street Address, Apt. No., or P.O. Box City State Zip Code*

Residential Address \_\_\_\_\_  
*Street Address, Apt. No., or P.O. Box City State Zip Code*

Housing: Permanent  Temporary  Program  Homeless

Gender: Male  Female  Transgender

Telephone ( ) \_\_\_\_\_ Are you 18 years of age or older? Yes  No

Email address \_\_\_\_\_

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

How did you learn about our training program? \_\_\_\_\_  
Please provide the name and number of the person or agency who referred you.

Did you participate in StepForward? Yes  No

Can you furnish proof of your eligibility to work in the United States? Yes  No

### REFERENCES

Please supply at least one (1) professional reference. (This can be a prior supervisor, employer, case manager, or someone else who can talk about your employment skills.) We do not require a personal reference.

|          |          |                  |
|----------|----------|------------------|
| 1. Name: | Address: | Telephone #: ( ) |
| 2. Name: | Address: | Telephone #: ( ) |



## PHYSICAL REQUIREMENTS FOR ALL TRAINEES

Trainees must be able to perform the following:

- Lift and/or move up to 40 pounds
- Specific vision abilities required include Close vision and Peripheral vision
- Ability to stand (up to 100% of the time) and walk
- Must be able to use hands to finger, handle, or feel; reach with hands and arms; stoop, kneel, crouch, or crawl
- Must be able to talk and hear

Applicant or Food Employee Name (please print) \_\_\_\_\_

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

## ADDITIONAL INFORMATION

We receive funding to support our training program. The following information on this page help us with our applications for future funding. Please consider answering the following voluntary questions.

**Race (please select as many as applicable):**

White/Caucasian  Latino/a  Black or African American  Asian

Native American or Pacific Islander  Other

**Ethnicity** Hispanic  European  Native American  African  Asian  Other

**Veteran:** Yes  No

**Are you currently working?** Yes  No

**Do you currently receive local, state, or federal assistance? (For example: Unemployment, Veterans Benefits, DTA, SSI/SSDI or Housing)** Yes  No

**PERSONAL STATEMENT:** PLEASE ANSWER THE QUESTIONS USING ALL OF THE SPACE PROVIDED.

**Please use back of the page if you need additional space.**

1. Please describe your job search over the past 6 months. Be as specific as possible include websites and specific jobs. Please bring your work search log if you have been completing one for unemployment or complete the one below.

---

---

---

---

---

---

---

---

2. What do you hope to gain from this program?

---

---

---

---

---

---

---

---

3. Where do you hope to be in six months?

---

---

---

---

---

---

---

---



# Food Employee Reporting Agreement

Preventing Transmission of Diseases through Food by  
Infected Food Employees

*The purpose of this agreement is to ensure that Food Employees and Applicants who have received a conditional offer of employment notify the Person in Charge when they experience any of the conditions listed so that the Person in Charge can take appropriate steps to preclude the transmission of foodborne illness.*

## I AGREE TO REPORT TO THE PERSON IN CHARGE:

### ***SYMPTOMS***

1. Diarrhea
2. Fever
3. Vomiting
4. Jaundice
5. Sore throat with fever
6. Lesions containing pus on the hand, wrist, or an exposed body part  
(such as boils and infected wounds, however small)
7. Eye pain, swelling, redness with discharge

### ***MEDICAL DIAGNOSIS***

Whenever diagnosed as being ill with Infectious Conjunctivitis, *Salmonella* Typhi (typhoid fever), *Shigella spp.* (shigellosis), *Escherichia coli* O157:H7, hepatitis A virus, *Entamoeba histolytica*, *Campylobacter spp.*, *Vibrio cholera spp.*, *Cryptosporidium parvum*, *Giardia lamblia*, Hemolytic Uremic Syndrome, *Salmonella spp.* (non-typhi), *Yersinia enterocolitica*, or *Cyclospora cayentanensis*.

### ***PAST MEDICAL DIAGNOSIS***

Have you ever been diagnosed as being ill with one of the diseases listed above? \_\_\_\_\_  
If you have, what was the date of the diagnosis? \_\_\_\_\_

### ***HIGH-RISK CONDITIONS***

1. Exposure to or suspicion of causing any confirmed outbreak of typhoid fever, shigellosis, *E. coli* O157:H7 infection, or hepatitis A
2. A household member diagnosed with typhoid fever, shigellosis, illness due to *E. coli* O157:H7, or hepatitis A
3. A household member attending or working in a setting experiencing a confirmed outbreak of typhoid fever, shigellosis, *E. coli* O157:H7 infection, or hepatitis A

I have read (or had explained to me) and understand the requirements concerning my responsibilities under 105CMR 590/1999 Food Code and this agreement to comply with the reporting requirements specified above involving symptoms, diagnoses, and high-risk conditions specified. I also understand that should I experience one of the above symptoms or high-risk conditions, or should I be diagnosed with one of the above illnesses, I may be asked to change my job or to stop working altogether until such symptoms or illnesses have resolved.

I understand that failure to comply with the terms of this agreement could lead to action by the food establishment or the food regulatory authority that may jeopardize my employment and may involve legal action against me.

Applicant or Food Employee Name (please print) \_\_\_\_\_

Signature of Applicant or Food Employee \_\_\_\_\_ Date \_\_\_\_\_

Signature of Permit Holder or Representative \_\_\_\_\_ Date \_\_\_\_\_



Customer Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Funding Source: American Recovery and Reinvestment Act (ARRA)

**PART III -- INTENSIVE EDUCATIONAL ASSESSMENT**

Grade Levels: \_\_\_\_\_ Reading \_\_\_\_\_ Math

How determined?  Test Test name: \_\_\_\_\_  Other If "other", describe method: \_\_\_\_\_

Fluency (if applicable): \_\_\_\_\_ SPL (BEST test) \_\_\_\_\_ Other score/outcome (if not determined by BEST test)

If "other score/outcome", please describe method: \_\_\_\_\_

Educational assessment conducted at: \_\_\_\_\_ completed on \_\_\_\_/\_\_\_\_/\_\_\_\_  
Name of organization Date

**PART IV -- CERTIFICATION OF CUSTOMER'S TRAINING PROVIDER SELECTION**

**Training Provider Information**

The customer has determined that s/he wishes to pursue training at:

Provider Name: Community Servings Course ID: \_\_\_\_\_

Program Name: The Teaching Kitchen Total Hours: \_\_\_\_\_

Address: 18 Marbury Terrace Jamaica Plain MA 02130  
(No.) (Street Name) (City/Town) (State) (Zip Code)

Contact Name: Rosario Dominguez Contact Phone (617) 522 - 7777 Start date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Contact Fax (617) 522 - 7770 Contact E-mail: rdominguez@servings.org End date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PROGRAM COSTS** ..... Tuition: \_\_\_\_\_  
Fees (e.g., registration): \_\_\_\_\_  
Other (e.g., books, uniforms, certification, tools): \_\_\_\_\_  
TOTAL PROGRAM COST: \$ \_\_\_\_\_

Pell Grant, other funding sources, ..... Provide amount: - \$ \_\_\_\_\_  
Loans, ..... Provide amount: - \$ \_\_\_\_\_

**TOTAL VALUE** ..... \$ \_\_\_\_\_

**TO BE COMPLETED BY CUSTOMER**

I, \_\_\_\_\_ (Print name),

Agree to provide and/or release employment and educational information to Training Provider and JCS staff.

Customer Signature: \_\_\_\_\_

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

Training Provider Signature: \_\_\_\_\_

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

EDIC/JCS Signature: \_\_\_\_\_

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

\_\_\_\_\_

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