VOCATIONAL REHABILITATION SERVICES
VRS/South Bay Recycling Offsite Trainee Program- Application of Interest
Submit application to 550 Quarry Rd, San Carlos or Fax # 650-596-5162; Schedule a tour: 650-722-6156

NAME______________________________ DATE OF BIRTH ________________

ADDRESS ____

CITY __________________________ STATE ______ ZIP CODE__________

Cell phone number: ________________ Alternative phone number: ________________

Where did you hear about this training program? ____________________________

What interests you about the VRS Offsite Training Program at South Bay Recycling?

____

What skills and abilities would you bring to the VRS Offsite Training Program at South Bay Recycling?

____

What are your long term career goals?

____

Are you currently enrolled in any of the following programs?

☐ GA ☐ CalFresh (Food Stamps) ☐ CalWORKS ☐ SSI ☐ SSDI ☐ MediCal

☐ Shelter/Housing ☐ Substance Abuse Program ☐ Mental Health Clinic ☐ VRS

If applicable, please list your case worker’s name and phone number:

____

Do you have an SSI/SSDI application pending? ☐ YES ☐ NO

Can you work full-time (8 hr. shift and sometimes over-time)? ________________

Are you available to work overtime, weekends & holidays as needed? ☐ YES ☐ NO

Can you work standing for long periods of time? ☐ YES ☐ NO

Can you lift up to 20 lbs. & carry & walk w/10 lbs., w/ occasional bending & stooping? ☐ YES ☐ NO

Are you a registered sex offender? ☐ YES ☐ NO

Have you ever been convicted of a violent crime? ☐ YES ☐ NO

____________________________ ____________________
Applicant Signature **Date**

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Name (Please print clearly): ________________________________

PHYSICAL CAPABILITIES ASSESSMENT

In my opinion….

I can lift and maneuver (how many?) ____ lbs frequently, ___ lbs occasionally.

Walking: My normal walking pace is ____ slow ____ medium ____ fast and I can walk

______miles.

Sitting: I can sit for

____ Less than 30 minutes before changing positions
____ 1 hour – 1.5 hours
____ 1.5 hours to 2.5 hours
____ 3 hours or more

Standing: I can stand for

____ Less than 30 minutes before changing positions
____ 1 hour – 1.5 hours
____ 1.5 hours to 2.5 hours
____ 3 hours or more

Climbing: I can climb stairs

____ Repeatedly ____ Occasionally ____ Not at all

I can climb ladders

____ Repeatedly ____ Occasionally ____ Not at all

Reaching: Reaching capabilities

____ No restriction
____ Causes pain or soreness
____ Unable to perform

Crawling: Crawling capabilities

____ No restriction
____ Causes pain or soreness
____ Unable to perform

Bending: Bending capabilities

____ No restriction
____ Causes pain or soreness
____ Unable to perform

Vision: ____ No limitation ____ Limitations ____ Color blindness

____ Right Eye ____ Left Eye

Hearing: ____ No limitation ____ Limitations

____ Right Ear ____ Left Ear

Name (Please print clearly): ______________________________

Feeling: ____ No limitation ____ Limitation. If limitation exists specify: _______________

Smelling: ____ Normal ____ Decreased ____ Unable to smell

Kneeling: Kneeling capabilities
____ No restriction
____ Causes pain or soreness
____ Unable to perform

Heart: ____ No limitation ____ Limitation. If limitation exists specify:

Have you ever had problems with your heart, your breathing **(i.e. asthma or dust allergies?),** or blood pressure? ☐Yes☐No If so, please describe:

What serious or prolonged illness, injuries, surgeries, and hospitalization have you had?

If none, please check here:☐

1) Problem: Date:
Treatment:
Location of treatment facility:
Treating physician:
Status:

2) Problem: Date:
Treatment:
Location of treatment facility:
Treating physician:
Status:

3) Problem: Date:
Treatment:
Location of treatment facility:
Treating physician:
Status:

Have you ever been injured on the job?

Have you ever had a problem with alcohol or drugs?

Do you have any of the following illnesses in your family:
____ Diabetes ____ Heart disease
____ High Blood Pressure ____ Other, explain:

Client signature Date

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