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: 650-802-6567

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**

Revised 10.2019

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