NEED HELP FINDING A JOB? NEED HELP MAKING A RESUME? HELP WITH INTERVIEW SKILLS?

Join the Employment Training Academy!

Bayfair ETA: 15555 E. 14th St. Suite 413, San Leandro, CA 94578 *510.481.0272
San Leandro and the Unincorporated Eden Area

Southland ETA: 5 Southland Mall, LL 43, Hayward, CA 94545 *510.783.0272
Hayward / Eden Area

Tri-Cities ETA: 1155 NewPark Mall, Newark, CA 94560 *510.794.2957
Fremont, Newark, and Union City

FREE TWELVE WEEK COURSE!

To be Eligible:

❖ You must live in **Alameda County** (San Leandro, Hayward, Fremont, Newark, Union City, or the unincorporated Eden Area (San Lorenzo, Castro Valley, etc.)

AND

❖ Be between the ages of **14-24 years old**

How to Join:

1. Complete the attached Application

2. Provide PROOF OF YOUR AGE & ADDRESS

Examples of proof of age:
School ID (with date of birth)
Birth Certificate (with a photo ID)
CA ID or CA Drivers License
Any combination of documents showing your birthday, address & photo

CONTACT US TODAY!

BETA: 510-783-0272 **Fax** 510.481.0198
SETA: 510-783-0272 **Fax** 510.481.0198
Tri-CETA: 510-794-2957 **Fax** 510.797.2851

EMPLOYMENT TRAINING ACADEMY Application

☐ **BETA** ☐ **SETA** ☐ **Tri-CETA**

NOTE: ALL INFORMATION WILL BE KEPT CONFIDENTIAL. IT IS REQUESTED TO ENSURE YOU ARE OFFERED ALL SERVICES YOU MAY QUALIFY FOR.

Name: _____ Date: _____

Birthday: _____ Age: _____ Social Security Number: _____

Street Address: _____ City: _____ Zip: _____

Phone: _____ Email Address: _____

1. What is your race/ethnicity? _____
2. Gender: Male / Female / Transgender **(please circle one)**
3. Currently enrolled in (please **circle one**): *middle school / high school / college / not in school*
   Please indicate (if applicable) **WHICH** school: _____ **GRADE/ YEAR:** _____ or WHEN you graduated from high school: _____)
4. How did you find out about the Employment Training Academy?
   _____
5. Would you be interested in talking to someone about things you are worried, sad, or angry about? **YES** **NO**
6. Do you receive Medi-Cal? **YES** **NO**
7. Do you or your parents receive CalWORKs? **YES** **NO**
8. Do you or your parents receive Food Stamp Benefits? **YES** **NO**

Please check any programs that you are interested in ***(2 minimum)***:

☐ GED/Diploma Courses
☐ Computer Lab
☐ Job Placement Programs
☐ Help With Getting into College
☐ Case Management (one-on-one support with your academic, personal, and career goals)
☐ Mental Health, Therapy, Support Groups (individual, family, group therapy)

NOTE: By signing this portion of the application you are verifying that it is complete with no missing information.

- I give my child permission to participate in programming at (BETA / SETA / Tri-CETA). I understand the programs and services offered at the ETA as well as the mission and vision of the center.
- My child has read the expectations and rules of the ETA and I understand that membership to the center is conditional. If my child does not abide by the rules I may need to have a conference with my child and a staff member and ultimately my child may be dismissed from the center indefinitely. My child is not to bring anything illegal to the center, including weapons of any kind or drugs and Alcohol.
- I hereby give my consent for ACAP to use my photograph and likeness to be used in its publications, including its website. I release them from any expectation of confidentiality for the undersigned minor children and/or myself and attest that I am the parent or legal guardian of the children listed below (for participants under 18 only).

Applicant: _____ **Date:** _____

Parent/guardian (minors only): _____ **Date:** _____

ETA Case Manager: _____ **Date:** _____

EMPLOYMENT TRAINING ACADEMY Emergency Form

SHOULD YOUR CHILD NEED MEDICAL TREATMENT WHILE PARTICIPATING IN A SANCTIONED ACTIVITY, THIS FORM WILL ACT AS BOTH THE INSTRUCTIONS SET FOR MEDICAL PROCEDURES AND REFERENCE FOR CONTACT

PARTICIPATION INFORMATION

First Name _____ Middle_____ Last Name_____

Address_____ Zip Code _____

Phone Number_____ Alternate Phone Number_____ Date of Birth_____

Can your daughter or son:

Receive emergency medical treatment if necessary? Yes No

Be taken to the nearest medical facility? Yes No

If no, please specify the facility your daughter or son should be taken to:

Facility _____

Does your son or daughter have healthcare insurance?

Yes No If yes:

Name of carrier _____ Address _____

Policy Number _____ Phone Number _____

Primary Care Physician (if any) _____ Phone Number _____

Medical History

Does the participant have any allergies to any medications or food products? Yes No

If yes, what are they? _____

Does the participant have and medical conditions that we should be aware of? Yes No

If yes, what are they? _____

Please list any special instructions regarding the medical treatment of the participant (please, include the names of any medications that are taken regularly)

_____

_____

PARENT/ GUARDIAN CONTACT INFORMATION

Name of Mother/Guardian: _____ Name of Father/Guardian: _____

Home Phone Number: _____ Home Phone Number: _____

Work Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____ Cell Phone Number: _____

In case the above are unavailable, who should we contact?

Name _____ Relationship _____

Phone Number _____ Alternate Phone Number _____

Should the need arise, I authorize the ETA staff, its affiliated agencies and/or any medical personnel to act in accordance to the above instructions. If in the event that the medical services needed are not clearly addressed above, I authorize staff, its affiliated agencies, and/or any medical personnel to exercise their best judgment in providing appropriate medical service.

Parent/Guardian_____ Date_____