



Application for Employment

Applicants for positions will be considered regardless of race, color, national origin, sex, age, religion, creed, marital status, ancestral heritage, sexual orientation, Vietnam Era Veteran status, or the presence of any physical, mental and/or sensory disability. This includes persons who have AIDS/HIV.

DIRECTIONS: *Please print or type. All sections of application must be completed in full. Attach personal resume to this completed application form is desired.*

Date of application:	
Position(s) Applying for: 1. _____ 2. _____	
Beginning Salary Expectation:	On what date would you be available to start?
Type of employment desired: <i>(Circle One)</i> <div style="display: flex; justify-content: space-between; width: 100%;"> Full Time Part Time On Call </div>	

PERSONAL			
Name-Last	First	M.I.	Maiden Name
Present Address-Number & Street		City	State Zip
Home Phone	Work Phone	May we contact you at work?	SSN

EDUCATION					
School	Name/Location of School	Course of Study	# Yrs Completed	Did you Graduate	Degree or Diploma
Graduate					
College					
Business/ Trade/ Technical					
High School/GED					
Other					

EMPLOYMENT HISTORY		
<i>Please list your employment history beginning with your most recent position. Do not reference personal resume.</i>		
Dates employed: From _____ To: _____		Position/Title:
Employer:		Telephone:
Address:		
Salary/Hourly Rate:	Start: _____ Final: _____	Hours worked/Week:
Duties:		
Supervisor's Name:		May we Contact?
Reason for Leaving:		

Dates employed: From _____ To: _____		Position/Title:
Employer:		Telephone:
Address:		
Salary/Hourly Rate:	Start: _____ Final: _____	Hours worked/Week:
Duties:		
Supervisor's Name:		May we Contact?
Reason for Leaving:		

Dates employed: From _____ To: _____		Position/Title:
Employer:		Telephone:
Address:		
Salary/Hourly Rate:	Start: _____ Final: _____	Hours worked/Week:
Duties:		
Supervisor's Name:		May we Contact?
Reason for Leaving:		

VOLUNTEER/INTERNSHIP/PRACTICUM EXPERIENCE

LICENSE

- Counselor Registration
- Certification (Type _____)
- Psychologist
- Psychiatrist (M.D./D.O.)
- ARNP
- RN
- LPN

WASHINGTON STATE:

License/Registration/Certification Number: _____

Exp. Date _____

If Applicable:

DEA # (M.D. ARNP) _____

DSHS Provider #: _____

Board Certified: Yes No

Board Eligible: Yes No

SPECIALISTS

- Qualified Chemical Dependency Counselor
- Child Mental Health Specialist
- Disabilities Mental Health Specialist (Specify _____)
- Ethnic Minority Mental Health Specialist (Specify _____)
- Mental Health Professional
- Geriatric Mental Health Specialist

Documentation will be required from previous supervisor(s) identifying his/her credentials, your full/part time status, your specific duties of employment, and the number of training hours you have received in the area of specialty.

SUPPORT APPLICANTS ONLY

Typing speed _____ WPM Dictaphone Data Entry Word Processing
Ten Key Fax Machine

Computer Skills _____

Hardware Knowledge _____

Software Knowledge _____

Maintenance Skills _____

Other Relevant Skills _____

CHECK ALL THAT APPLY SPECIFY WHERE INDICATED

- Drivers License
- Drivers license for at least 7 years
- Proof of auto insurance
- Current documentation of First Aid/CPR
- Current Food Handler's Permit
- Travel within the area if the position requires
- Can work OT, Weekends, and other non-traditional hours
- I have been employed with this agency in the past If checked, Explain _____
- Have a private business
- Am Employed somewhere else If checked, where _____
- Have been convicted of a felony If Checked, explain _____

READ CAREFULLY THE FOLLOWING STATEMENTS AND AGREEMENT

Only US citizens and others lawfully authorized to work in the United States will be hired.

I certify that the information contained in this application is correct to the best of my knowledge and that any false or misleading information provided is grounds for dismissal or rejection of my application for employment

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

I agree that my previous employers may release all information regarding my employment history and I hereby release my previous employers and this agency from all claims and liabilities arising from the release of such information. This includes references listed on my employee reference form.

This application for employment will be considered active for a period not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at that time.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment with this agency is of an "at will" nature, which means that the Employee may resign at any time and the Community House Mental Health may discharge the Employee at any time with or without cause. It is further understood that this "at will" employment relationship may not be changed by any statement, conduct or written document, unless such a change is specifically acknowledged in writing by both an authorized executive of Community House Mental Health and the Employee.

The contents of this application do not constitute an express or implied contract of employment.

In the event of employment, I understand that I am required to abide by all rules and regulations of Community House Mental Health.

Signature of Applicant: _____

Date: _____



Acknowledgement of Background Check

Washington State requires employees who work with vulnerable adults to obtain a background check. An applicant is conditionally employed pending the results of the individual's background check.

A request will be made within 3 business days of conditional employment. The administrator will be verbally informed of the inquiry results within 2 working days of receipt.

If requested, the administrator will provide a copy of the background check results for the individual.

Employee: _____ Date: _____

Background Authorization

Read the attached instructions before completing this form.

SECTION 1. ENTITY INFORMATION (COMPLETED BY DSHS STAFF, PROVIDER, APPLICANT, LICENSEE, AND/OR CONTRACTOR)				
1A. GIVE NAME OF PERSON OR ENTITY REQUESTING THIS BACKGROUND CHECK		1B. SEE INSTRUCTIONS: GIVE ENTIRE ADDRESS OF PERSON OR ENTITY REQUESTING THE CHECK		1C. REQUIRED BY CHILDREN'S ADMINISTRATION ONLY: GIVE NAME OF FACILITY/FOSTER HOME
2. NAME AND SIGNATURE OF PERSON REQUESTING THE BACKGROUND CHECK				
PRINTED NAME:			SIGNATURE:	
3. A. REQUIRED ONLY FOR ECONOMIC SERVICES ADMINISTRATION:				
<input type="checkbox"/> WorkFirst contract <input type="checkbox"/> Protective Payee <input type="checkbox"/> In-home relative <input type="checkbox"/> In loco parentis				
B. REQUIRED ONLY FOR CHILDREN'S ADMINISTRATION:				
<input type="checkbox"/> State foster care <input type="checkbox"/> Private agency foster care <input type="checkbox"/> Adoption <input type="checkbox"/> DCFS relative placement <input type="checkbox"/> Contracts <input type="checkbox"/> Subject of (or related to) CPS investigation <input type="checkbox"/> Residential facility or child placing agency employee				
C. REQUIRED ONLY FOR ADULT PROTECTIVE SERVICES:				
<input type="checkbox"/> Subject involved in (or related to) APS investigation per RCW 74.34				
D. REQUIRED ONLY FOR DSHS STATE EMPLOYMENT:				
DSHS POSITION NUMBER _____ (WRITE NONE IF NONE) DSHS JOB CLASSIFICATION: _____ PERSONNEL IDENTIFICATION NUMBER: _____				
<input type="checkbox"/> Permanent appointment <input type="checkbox"/> Non-permanent appointment <input type="checkbox"/> Work study <input type="checkbox"/> Volunteer <input type="checkbox"/> Student internship <input type="checkbox"/> Layoff <input type="checkbox"/> On-Call				
4. SEE INSTRUCTIONS: BCCU ACCOUNT NUMBER		5A. SEE INSTRUCTIONS: DSHS ID NUMBER OR NAME		5B. FOR WEB SERVICE FINGERPRINT CHECK: BCCU INQUIRY ID NUMBER
SECTION 2. THIS SECTION IS FOR APPLICANT INFORMATION ONLY (THE PERSON TO BE CHECKED IS THE APPLICANT)				
6. SEE INSTRUCTIONS: SOCIAL SECURITY NUMBER			7. PRINT YOUR DATE OF BIRTH (MM/DD/YYYY)	
8A. SEE EXAMPLE IN INSTRUCTIONS: PRINT YOUR LAST NAME AS IT IS NOW (WRITE NONE IF NONE)		SEE EXAMPLE IN INSTRUCTIONS: PRINT YOUR FIRST NAME AS IT IS NOW (WRITE NONE IF NONE)		SEE EXAMPLE IN INSTRUCTIONS: PRINT YOUR MIDDLE NAME AS IT IS NOW (WRITE NONE IF NONE)
8B. PRINT YOUR LAST NAME AT BIRTH (WRITE NONE IF NONE)		PRINT YOUR FIRST NAME AT BIRTH (WRITE NONE IF NONE)		PRINT YOUR MIDDLE NAME AT BIRTH (WRITE NONE IF NONE)
9. PRINT OTHER LAST NAMES YOU HAVE USED AND LAST NAMES YOU HAVE BEEN KNOWN BY (WRITE NONE IF NONE)				
10. PRINT YOUR NICKNAMES AND ALL OTHER FIRST NAMES YOU HAVE USED AND HAVE BEEN KNOWN BY (WRITE NONE IF NONE)				
11A. Have you been convicted of any crime? If yes, fill in the blanks below. Add a page if you need more room. <input type="checkbox"/> Yes <input type="checkbox"/> No				
Felony and gross misdemeanor crimes: _____ Degree: _____ State: _____ Conviction date: _____				
11B. Do you have charges (pending) against you for any crime? If yes, fill in the blanks below. Add a page if you need more room. <input type="checkbox"/> Yes <input type="checkbox"/> No				
Felony and gross misdemeanor crimes: _____ Degree: _____ State: _____				
12. Have you ever received a notice from a court or state agency stating that you have sexually abused, physically abused, neglected, abandoned, or exploited a child, juvenile, or adult? <input type="checkbox"/> Yes <input type="checkbox"/> No				
13. Has a court or state agency ever denied you a contract or license; terminated, revoked or suspended your contract or license; or have you ever given up your contract or license because a court or agency was taking action against you? <input type="checkbox"/> Yes <input type="checkbox"/> No				
14. Has a court ever written an order of protection or a restraining order lasting more than 30 days against you for abuse, neglect, financial exploitation, domestic violence, or abandonment of a vulnerable adult, juvenile, or child? <input type="checkbox"/> Yes <input type="checkbox"/> No				
15. PRINT YOUR DRIVER'S LICENSE OR STATE IDENTIFICATION NUMBER (WRITE NONE IF NONE)			PRINT THE NAME OF THE STATE ON YOUR LICENSE OR ID	
16. How many years have you lived in Washington State without living in another state? _____ Years / _____ Months				
17. A. PRINT THE STREET ADDRESS WHERE YOU LIVE NOW				
		CITY	STATE	ZIP CODE COUNTY
B. SEE INSTRUCTIONS: PRINT THE STREET ADDRESS WHERE YOU LIVED BEFORE YOUR CURRENT ADDRESS				
		CITY	STATE	ZIP CODE COUNTY
C. SEE INSTRUCTIONS: GIVE THE DAYTIME AREA CODE AND TELEPHONE NUMBER WHERE YOU CAN BE REACHED				
18. I am the person named above. If I do not tell the whole truth on this form, I understand I can be charged with perjury and I may not be allowed to work with vulnerable adults, juveniles or children. My signature in box number 19 means:				
<ul style="list-style-type: none"> • I give DSHS permission to check my background with any governmental entity and law enforcement agency. • If a founded finding is identified, I give DSHS permission to give only my name and that a founded finding was identified to any persons or entities in Section 1. • I give DSHS permission to give all my other background information to the persons or entities named in Section 1. • This permission is good for 90 days from the date signed. I can change my mind about this permission in writing at any time. 				
19. REQUIRED: YOUR SIGNATURE. YOUR PARENT OR GUARDIAN'S SIGNATURE IF YOU ARE UNDER 18.			20. REQUIRED: TODAY'S DATE (MM/DD/YYYY)	
FOR USE BY CHILDREN'S ADMINISTRATION STAFF ONLY				
CAMIS files checked by _____ on date _____ <input type="checkbox"/> No information found <input type="checkbox"/> Information available				