Upper Bay Counseling & Support Services, Inc.
200 Booth Street, Elkton, MD 21921
Phone: 410-996-5104
Fax: 410-996-5197

Position: ______________________
Date Employed: ______________________
Unit or Dpt.: ______________________
Salary: ______________________
Status: ❑ FT ❑ PT ❑ T ❑ FFS
Work Schedule: ______________________
Replacement: ______________________
Addition: ______________________

Date: ______________________

The employment policies of UBCSS are to recruit and hire qualified employees without discrimination because of race, religion, creed, color, age, sex, marital status, national origin, citizenship status, ancestry, disability, veteran status, communication ability or sexual orientation and to treat them equally with respect to compensation and opportunities for advancement – including upgrading, promotion and transfer –consistent with individual skills and the needs of UBCSS.

Please print:

Name: ____
Last First Middle

Address: ____
Street & Number City State Zip

Telephone: ______________________ Cell Number: ______________________

Email: ____

SECTION I

Employment Desired

Position Applying For: ______________________ ☐ Full-time ☐ Part-time

Hours Preferred: ______________________ Date available to start work: ______________________

Have been previously employed by UBCSS? ❑ Yes ❑ No

If so, Position? ______________________ When? ____________ Supervisor? ____________

Salary Expectation: ______________________

Personal

Are you currently charged, excluded, suspended, debarred, or otherwise ineligible to participate in the federal health care programs, including Medicare and Medicaid? ❑ Yes ❑ No

Have you ever been discharged from employment? ❑ Yes ❑ No

Have you ever been discharged from employment due to abuse of residents or clients?

❑ Yes ❑ No If yes, explain: ______________________

How did you learn about UBCSS? ______________________

Have you or anyone you know ever been in treatment here (if so, when) ______________________________________

Who referred you? ____

Why are you interested in working for UBCSS? ____

____

After reviewing the functions of the position you are applying for, do you have the ability to perform the essential functions of the position in a reasonable manner? ❑ Yes ❑ No
Note to applicant: *Do not answer this question unless you have been informed about the requirements of the position.*

Educational Data

Name & Address of Sr. High, College, University, Graduate School & Post Graduate School	*No. of years attended*	*Major*	*Degree*	*Date Conferred*
High School				

Subject Matter of Thesis and/or Dissertation: ____

____

Fellowships *(if teaching fellowships, name course taught; if research, name area of study)*

Field of Study	*University*	*From Month/Year*	*To Month/Year.*	*Supervisor*

Internship/Residency/Practicum

Agency: Public-Private, Clinic, Hospital, School	*From Month/Year*	*To Month/Year.*	*Responsibilities*	*Supervisor*

List all professional Licenses and/or Certificates

License/Certificate ______ State-issuing Organization ______ Number ______ Date Issued ______

License/Certificate ______ State-issuing Organization ______ Number ______ Date Issued ______

License/Certificate ______ State-issuing Organization ______ Number ______ Date Issued ______

Previous Employment Record
(List previous 5 years, if applicable)

List most recent employment first

From	*To*	*Employer Name Address & Phone*	*Position*	*Salary*	*Reason for Leaving*

May we contact your present employer for references? ❑ Yes ❑ No

Employment/Professional References

Name	*Relationship to Candidate*	*Title*	*Organization*	*Address & Telephone*

Personal References

Name	*Address*	*Occupation*	*Telephone*

Friends or Relatives Employed by UBCSS *(including relatives by marriage)*

Name	*Location*	*Relationship*

Do you have any plans for continuing your education or training? If so, what are your plans?

____

____

____

____

Describe any education, training, or specialized equipment knowledge you have received which would be applicable for work with UBCSS.

____

____

____

____

SECTION II

Criminal Background
Please complete as fully as possible.

Have you been convicted of a criminal offense related to the provision of health care items or services and have not been reinstated in the federal health care programs? ❑ Yes ❑ No

Have you ever been convicted of a misdemeanor (other than a traffic violation)? ❑ Yes ❑ No
A felony: ❑ Yes ❑ No

If yes, explain and give date of conviction? ____

(Conviction will not be an absolute bar to employment except as requested by law.)

Do you have a history of or conviction for a violent crime? ❑ Yes ❑ No

If yes, explain: ____

Have you ever had a finding of abuse or neglect? ❑ Yes ❑ No

Do you have any civil conviction? ❑ Yes ❑ No

Have you been adjudged civilly or criminally liable for abuse of a mentally challenged individual? ❑ Yes ❑ No

If YES, please provide details such as the nature of the conviction/finding and circumstances surrounding the conviction/finding. Date of age when committed or finding issued. Was the conviction/finding an isolated incident, and evidence of rehabilitation?

____

____

____

____

____

SECTION III

Please complete this section if you are a licensed clinician. If not, please check here: ❑ Not Applicable

Practitioner Checklist

Degree: ______________________________ License Type: ________________________ State: __________

Number: ______________________________ Date Issued: _________________ NPI#: __________________

Taxonomy Code: _______________________________

Directions Check yes or no for each item as it applies to your professional clinical background. For each item checked yes, attach a detailed description of the event, including copies of relevant documentation. Failure to provide sufficient information required determining a clear understanding of the nature and outcome of the event can result in rejection of your application.

Question	Answer
1. Has your professional liability insurance ever been denied, canceled or not renewed?	❑ Yes ❑ No
2. Have you ever had your medical or professional license or registration revoked, suspended or limited?	❑ Yes ❑ No
3. Have you ever voluntarily relinquished your professional license or registration when there was a challenge or pending challenge to the professional license?	❑ Yes ❑ No
4. Is there a pending challenge to your professional license or registration?	❑ Yes ❑ No
5. Has your professional or clinical staff membership ever been voluntarily or involuntarily suspended or terminated?	❑ Yes ❑ No
6. Have you ever surrendered your clinical privileges upon threat of censure, restriction, suspension, or revocation of such privileges?	❑ Yes ❑ No
7. Has Medicare, Medicaid, or any other federal, state or local authority brought charges against you for alleged inappropriate rates, billing or quality of care issues?	❑ Yes ❑ No
8. Have you ever been named as a defendant in any criminal proceeding?	❑ Yes ❑ No
9. Have you ever been convicted in any crime involving the abuse of minors?	❑ Yes ❑ No
10. Have you ever been the subject of disciplinary actions by any professional association or organization, e.g., licensing board?	❑ Yes ❑ No
11. Has your facility membership in any medical or other professional school ever not been renewed or subject to disciplinary action?	❑ Yes ❑ No
12. Are there any current health problems that make you unable to carry out any essential professional duties as defined by the requested appointment and privileges, and your job description in the agency under the contract being sought?	❑ Yes ❑ No
13. Are you aware of any pending malpractice claims?	❑ Yes ❑ No
14. Have you ever had any malpractice claims settled?	❑ Yes ❑ No
15. Have you ever been debarred from contracting with the State of Delaware, any other state or the government of the United States?	❑ Yes ❑ No
PSYCHIATRISTS ONLY	
16. Have you ever had your permit to prescribe drugs revoked or suspended?	❑ Yes ❑ No
17. Has your specialty board status ever been suspended, diminished, revoked or not renewed?	❑ Yes ❑ No

SECTION IV

Authorization to Release Information

I, ____, hereby authorize you, as a former employer, (herein the "Company") to release and disclose to Upper Bay Counseling & Support Services, Inc. ("Upper Bay"), and its agents, information pertaining to my employment. I release the Company and Upper Bay Counseling and their employees or agents from any damages, liabilities, and/or claims that may result from the release and indemnify Upper Bay Counseling (and its agents and employees) against any liability that may result from asking inquiries about me to that Company.

I hereby further authorize that a photocopy of the authorization may be considered as valid as an original.

Date: ______________________ Signature: ____

Other names used at the Company, if applicable: ____

SECTION V

Education Verification

Name of Applicant: ____________________________________ Social Security Number: __________________

Name & Address of School: ____

____

For HR Use Only

Name, title & phone of person supplying information: ____

____

Degree: ________________________________ Major: __________________________________

Date Graduated: _________________________ Other: __________________________________

SECTION VI

Driver's Supplement to Pre-Employment Application

Name: ______________________________ Job Title: ______________________________

Driver's License No: ______________________________ State: ______________________________

Expiration Date: ______________________________ Home Phone: ______________________________

Is your license under suspension? ❑ Yes ❑ No

Has your license been revoked? ❑ Yes ❑ No

Are you 21 years old or older? ❑ Yes ❑ No

Is your driver's license restricted? ❑ Yes ❑ No If yes, explain: ______________________________

Do you have points against your license: ❑ Yes ❑ No If yes, number of points: __________________

I hereby authorize Upper Bay Counseling and its affiliates or agents to investigate my driver's record. I certify that the above information is complete and correct to the best of my knowledge. I understand that before Upper Bay Counseling takes an adverse action against me based on the information acquired in the driver's license check, Upper Bay Counseling will provide me with a copy of the report.

SECTION VII

Computer Skill Survey

Please answer the following questions:

Hardware

1. Can you identify the following:

Mouse	❑ Yes	❑ No	❑ Maybe
Keyboard	❑ Yes	❑ No	❑ Maybe
Monitor	❑ Yes	❑ No	❑ Maybe
Power	❑ Yes	❑ No	❑ Maybe
Network	❑ Yes	❑ No	❑ Maybe
Printer	❑ Yes	❑ No	❑ Maybe
Modem	❑ Yes	❑ No	❑ Maybe
Looking at the network port on the PC (assuming the network cable is plugged in) can you tell if you have a network connection?	❑ Yes	❑ No	❑ Maybe

General Computing

2. Do you know how to add the following devices to your PC?

Local printer	❑ Yes	❑ No	❑ Maybe
Network Printer	❑ Yes	❑ No	❑ Maybe

3. Do you know how to do the following:

Create a desktop shortcut	❑ Yes	❑ No	❑ Maybe
Log off the PC without shutting down	❑ Yes	❑ No	❑ Maybe
Lock/Unlock the PC	❑ Yes	❑ No	❑ Maybe
Change password without being prompted	❑ Yes	❑ No	❑ Maybe
Map a network drive	❑ Yes	❑ No	❑ Maybe
Open an application from the start menu	❑ Yes	❑ No	❑ Maybe
Access Remote Desktop	❑ Yes	❑ No	❑ Maybe
Open/Save a file from a network location	❑ Yes	❑ No	❑ Maybe

4. Rate yourself on what you feel your level of knowledge is in each of the following applications using a scale from 1 to 10.

    1 Having never used the application
    5 Having used the application and familiar with basic functions, such as formatting, summation, and having used some higher level functions
    10 Having designed databases, macros, mail merge, effect driven presentations, and used all higher functions

Application	Rating
Microsoft Word	1 2 3 4 5 6 7 8 9 10
Microsoft Excel	1 2 3 4 5 6 7 8 9 10
Microsoft PowerPoint	1 2 3 4 5 6 7 8 9 10
Microsoft Publisher	1 2 3 4 5 6 7 8 9 10

Additional Comments: ____

____

APPLICANTS CERTIFICATION AND AGREEMENT

It is unlawful in Maryland to require or administer a lie detector test as a condition of employment or continued employment. An employer who violates this law is subjected to criminal penalties and civil liabilities. I hereby certify that the facts set forth in the above employment application are true and complete to the best of my knowledge. I understand that if employed, falsified statements shall be considered cause for dismissal. I further understand that during my orientation period, my employment and compensation can be terminated, with or without cause and without notice at anytime, and that following my orientation period my employment and compensation can be terminated at anytime, with or without notice, for any reason deemed sufficient by Upper Bay Counseling & Support Services, Inc. (UBCSS). In addition, I agree during my employment with UBCSS I will report to the Corporate Compliance Office if I am charged, excluded, suspended, debarred, or otherwise ineligible to participate in the federal health care programs, including Medicare and Medicaid. I understand that if charged with violation or otherwise found ineligible to participate in federal health program that I will be removed from employment with UBCSS and may not reapply until the resolution of such charges, criminal action, suspension, or proposed exclusion. By accepting employment I agree to these conditions.

I realize that I may undergo an investigation before or at any time of employment as per state law, conducted by the appropriate state and federal agencies. If I am involved in direct care, this investigation must be completed before I begin employment.

I understand that a drug test may be required at UBCSS after being offered employment, but before being employed and employment is contingent upon the satisfactory results of said test. I hereby authorize UBCSS to investigate all information pertinent to my application for employment. I understand that any offer of employment may be rescinded if my references are inadequate or unacceptable to UBCSS in its absolute and sole discretion. I understand that if hired, my employment at UBCSS is temporary and contingent upon the receipt of acceptable results from my criminal background checks so that I am eligible to participate in the federal health care programs, including Medicare and Medicaid. Again, I am aware that employment is contingent upon the satisfactory results of reference checks and other background checks.

____ ____________________

Signature **Date**

(If accepted for employment, you must furnish documentation of proof of identity, authorization to work in the United States, and have a drug test performed within 72 hours of hire.)